Health History Today's Date_____/_____/_____

Patient Name_____ Date of Birth_____/_____/_____

Referred By_____

List All
Surgeries_____

_____

List Past Medical Problems_____

_____

List Current Medical Problems_____

_____

List Allergies_____

_____

List Current Medications, Dose, When and How Taken_____

_____

List Current Vitamins and Supplements_____

_____

Are You Seeking a Skincare Solution (circle one) Yes No If Yes, What Are Your Concerns? (Wrinkles, Acne, etc)

_____

_____

Smoking (circle one) Never Previous Current If You Quit, When? How Much Per Day Do You/Did You Used To Smoke?_____ Pack(s) Every_____(circle one) Day(s) Week(s)

Do You Drink Alcohol? (circle one) Yes No If Yes, What Kind Of Alcohol? (Beer, Liquor, etc)_____

How Much and How Often?_____

Do You Consume Caffeine? (circle one) Yes No If Yes, How Much and How Often?_____

Family History

(Please Include Mother, Father, Brothers, Sisters, Self)

Is There A Family History of (circle one; if yes, please specify relation, type of disease, and whether or not relative is currently living.)

Cancer? Yes No

_____

Diabetes? Yes No

_____

Heart Disease? Yes No

_____

High Blood Pressure? Yes No

_____

High Cholesterol? Yes No

_____

Other? Yes No

_____

Is There Anything Else That We Need To Know In Order To Provide You With The Highest Quality of Care?

_____
_____
_____
_____
_____
_____
_____
_____

_____ ___/___/_____

Signature Date