



## Health Information Questionnaire

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City & Zip \_\_\_\_\_

Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Email: \_\_\_\_\_ Date of Birth \_\_\_\_\_

How did you hear about us: \_\_\_\_\_

Have you ever had any of the following conditions? Check all that apply:

<input type="checkbox"/> AIDS	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Anemia	<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Asthma	<input type="checkbox"/> Lupus
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Mental disorder
<input type="checkbox"/> Cold Sore	<input type="checkbox"/> Nervous Disorder
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Skin Conditions
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Stroke
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Pregnant/Lactating	<input type="checkbox"/> Any other concerns

Have you ever had any of the following Cosmetic Treatments? If so Check and Date

<input type="checkbox"/> Chemical Peel	<input type="checkbox"/> Microderm Abrasion
<input type="checkbox"/> Botox/Dysport	<input type="checkbox"/> IPL/Laser Hair Removal
<input type="checkbox"/> Dermal Filler	<input type="checkbox"/> Lipo
<input type="checkbox"/> Facial Surgery	<input type="checkbox"/> Retin-A
<input type="checkbox"/> Laser Surgery	<input type="checkbox"/> Accutane

Check or list all the Allergies that apply:

<input type="checkbox"/> Medications:	
<input type="checkbox"/> Cosmetics:	
<input type="checkbox"/> Cow Milk Protein:	
<input type="checkbox"/> Latex/Other:	

What procedures or products are you interested in? Check all that apply

<input type="checkbox"/> Microderm Abrasion/Chemical Peel	<input type="checkbox"/> Botox/Dysport
<input type="checkbox"/> Photo Facial, Sun Spot Removal	<input type="checkbox"/> Laser Hair Removal
<input type="checkbox"/> Medical Weight Loss Program	<input type="checkbox"/> Obagi Skin Care
<input type="checkbox"/> Cellulite Reduction	<input type="checkbox"/> Mineral Make-Up
<input type="checkbox"/> Liposelection/Vaser/Lipotherme	<input type="checkbox"/> Dermal Filler
<input type="checkbox"/> Latisse-eyelash enhancer	<input type="checkbox"/> Other: