NAME: _____ **DATE OF BIRTH:** _____

REASON FOR YOUR CONSULTATION TODAY:

_____

PLEASE LIST **ALL MEDICATIONS** (INCLUDING ANY OVER THE COUNTER OR VITAMINS) THAT ARE TAKEN ON A REGULAR BASIS:

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

PLEASE LIST **ALL DRUG ALLERGIES** OR ANY ADVERSE DRUG REACTIONS:

_____

PLEASE LIST ANY ILLNESS OR CONDITION THAT YOU ARE FOLLOWED BY AN MD FOR: _____

_____

DOES **YOUR** PERSONAL MEDICAL HISTORY INCLUDE ANY OF THE FOLLOWING:

____ Diabetes	____ Hepatitis, Type ____	____ Anemia	____ Keloids
____ Cancer	____ Thyroid Condition	____ Eczema	____ Ulcers
____ Asthma	____ Sun Sensitivity	____ Emotional Disorder	____ Heart Disease
____ Emphysema	____ Cystic Breasts	____ Cold Sensitivity	____ Poor Wound Healing
____ Tuberculosis	____ High Blood Pressure	____ Hives	____ Glasses / Contacts
____ Lung Disease	____ Kidney Disease	____ Sinus Problems	

HAVE YOU HAD ANY OPERATIONS OR BEEN HOSPITALIZED FOR ANY REASON? YES _____ NO _____

PLEASE LIST ALL DATES AND REASONS:

_____

_____

_____

DO YOU HAVE EXCESSIVE BLEEDING OR BRUISING? YES___ NO___ **(**IF YES, PLEASE EXPLAIN):

_____

DO YOU TAKE ASPIRIN ON A REGULAR BASIS? YES_____ NO_____ DOSE: _____

DO YOU SMOKE OR USE ANY NICOTINE PRODUCT: YES ___ NO___ IF SO, HOW MUCH?: _____

DO YOU DRINK ALCOHOL?: YES ____ NO ____ IF SO, HOW MUCH?: _____

ARE YOU CURRENTLY USING ANY SKINCARE PRODUCTS:_____

WOULD YOU LIKE INFORMATION ABOUT PRODUCTS WE OFFER? *YES___ NO___*