Health History

List All Surgeries_____

_____

List Past Medical Diagnosis:_____

_____

List Current Medical Diagnosis_____

_____

List Allergies_____

_____

List Current Medications, Dose, When and How Taken_____

_____
_____

List Current Vitamins and Supplements_____

_____
_____

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?_____

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

Family History

Is There a Family History of (circle one; if yes, please specify relation, type of disease, and whether or not relative is currently living. Include Mother, Father, Brothers, Sisters, Self.)

Cancer? Yes No _____

Diabetes? Yes No _____

Heart Disease? Yes No _____

High Blood Pressure? Yes No _____

High Cholesterol? Yes No _____

Other? Yes No _____

Signature_____ Date___/___/_____