Name:_____ Today's Date:_____

Age:_____ Birthdate:_____ Height:_____Weight:_____

Current Occupation:_____ ☐Full Time ☐Part Time ☐ Retired

What specific area of cosmetic improvement are you interested in?: _____

Check any and all health conditions you currently have or have had in the past year:

☐AIDS	☐Chemical Dependency	☐Hernia	☐Pacemaker
☐Alcoholism	☐Chicken Pox	☐Herpes	☐Pneumonia
☐Anemia	☐Colitis/Crohn's Disease	☐High Cholesterol	☐Polio
☐Anorexia	☐Depression	☐HIV Positive	☐Parkinsons Disease
☐Appendicitis	☐Diabetes	☐Hypertension	☐Prostate Problem
☐Arthritis	☐Emphysema	☐Irritable Bowel Syndrome	☐Psychiatric Care
☐Asthma	☐Fibromyalgia	☐Kidney Disease	☐Stroke
☐Bleeding Disorders	☐Epilepsy	☐Liver Disease	☐Suicide Attempt
☐Breast Lump	☐GERD	☐Measles	☐Thyroid Problems
☐Bronchitis	☐Glaucoma	☐Migraine Headaches	☐Tonsillitis
☐Bulimia	☐Goiter	☐Miscarriage	☐Tuberculosis
☐CABG	☐Gout	☐Mononucleosis	☐Ulcers
☐Cancer	☐Heart Disease	☐Multiple Sclerosis	☐Vaginal Infections
☐Chronic Fatigue Syndrome	☐Hepatitis A, B, C	☐Mumps	☐Venereal Disease

Health Habits:

Cigarettes/Cigars per day_____ How long_____ Quit/When_____

Coffee: # cups per day_____ Soda: # cans per day_____

Water: # cups per day_____ Alcohol use:_____ Number/day_____

Exercise: ☐ 5-7 days per week ☐ 3-4 days per week ☐ 1-2 days per week

☐ 45 minutes or more duration per workout ☐ 30-45 minutes duration per workout ☐ Less than 30 minutes

☐ Aerobics ☐ Cycle ☐Walk ☐ Run/Jog ☐Weight Lift ☐Swim ☐ Yoga ☐ Other_____

Medications	Current Herbal/Vitamins/Minerals/Supplements	

Allergies: _____

Cosmetic Procedures & Surgeries, including chemical peels, laser, etc.

Year	Type	Year	Type

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or nurse practitioner or any members of his staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Signed Date