CLIENT INFORMATION & MEDICAL HISTORY

In order to provide you with the most appropriate treatment, we need you to complete the following questionnaire. All information is strictly confidential.

PERSONAL HISTORY

Client Name _____ Today's Date_____

Date of Birth_____Age_____Occupation_____

Home Address_____City_____
State___Zip Code_____Home Phone (__)_____ Cell Phone (____)_____
Email_____
Emergency Contact Name/Phone:_____

How were you referred to us? _____

How did you hear about us? (Please circle one) Google Yelp 4Memphis Magazine
TalkWith Me (phone app) Social media (ex.facebook,Instagram)
OTHER:_____

Do you regularly sun bathe or use tanning salons?_____How often? _____

MEDICAL HISTORY

Are you currently under the care of a physician? Yes □ No □

If yes, for what:_____

_____

Do you have any of the following medical conditions? (Please check all that apply)

Cancer □ Diabetes □ High blood pressure □ Post stroke□ Arthritis □ Frequent cold sores □
HIV/AIDS □ Keloid scarring □ Skin disease/Skin lesions □ High Chol □ Chronic HA □ ADHD □

Seizure disorder □ Hepatitis □ Hormone imbalance □ Thyroid imbalance □ Blood

Clotting Abnormalities □ Recent Surgery □ Eye Disorders □ Depression□ Anxiety □

Herpes Simplex □ Autoimmune □ Any active infection □ Smoke □

Do you have any other health problems or medical conditions? Please list: _____

_____

Have you ever had an allergic reaction? (List any and all that you have had and describe the reaction you experienced) Food _____ Animal Protein _____ Aspirin_____ Lidocaine _____ Hydrocortisone _____ Hydroquinone or skin bleaching agents____ Shell Fish_____ Iron_____Eggs_____Cosmetics_____Fabrics_____Chemicals_____Latex____Others_____

MEDICATIONS

What oral prescription medications are you presently taking? Birth control pills_____

Hormones _____ Others (It is required that you list all of them): _____

_____

What antibiotics do you use to treat infections?_____

_____

Do you take any medications for heart conditions? _____

_____

Are you on any mood altering or anti-depression medication? _____

What topical medications or creams are you currently using? RetinA , Others (Please list):

_____

What herbal supplements do you use regularly?_____

Are You Currently Taking Aspirin, Aspirin containing products, or any other blood thinning medications such as; Coumadin, Plavix, Heparin, herbal blood thinning products? Please list or N/A_____

HISTORY

For our female clients:

Are you pregnant or trying to become pregnant? Yes No Are you breastfeeding? Yes No Are you using contraception? Yes No

I certify that the preceding medical, medication and personal history statements are true and correct. I am aware that it is my responsibility to inform the doctor or other health professional of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Signature_____ Date:_____

FNP or Physician Signature _____