TO HELP US SERVE YOU BETTER, PLEASE TAKE A MOMENT TO COMPLETE THIS INFORMATION

Today's Date: _____________

Last Name: __________________________________ First Name: ______________________________ MI: _____

Nick Name: ___________________________

Date of Birth: ____________________ Age: ___________

Street Address: ____P.O. Box Number: _______________

City: ____ State: ____________ Zip Code: ___________

Email address **(Please Print Legibly):**

____

YOUR EMAIL ADDRESS IS OUR PREFERRED MEANS OF CONTACTING YOU

Preferred phone number for contact: HOME_________________CELL__________________WORK________________

Occupation: ____

May we send you an email for appointment reminder information? ◻ Yes ◻ No
…for medical or additional scheduling information? ◻ Yes ◻ No
…for notifying you of our monthly specials? ◻ Yes ◻ No
May we send you regular mail? ◻ Yes ◻ No

Marital Status:
◻ MARRIED ◻ DIVORCED ◻ SINGLE or NEVER MARRIED ◻ WIDOW ◻ LIVING WITH SIGNIFICANT OTHER

Ethnicity: ◻ Hispanic ◻ Asian ◻ Not Hispanic or Asian

Language: ◻ English ◻ Spanish ◻ Other ________________

In case of an **emergency**, whom should we notify?

Contact Name: _______________________________________ Relationship: _______________ Phone: __________________

Who may we release **medical or appointment information** to?

Name: _______________________________________Relationship: _____________________________

Preferred Pharmacy: ____

Location: _______________________________ Phone number (if available): _________________

Preferred Lab: ____Location: ______________________________

Primary Physician: ____ Phone: ________________

How did you hear about us? (Please check all that apply):
◻ Internet ◻ Magazine ◻ Newspaper ◻ Billboard ◻ Mailer ◻ Staff Member ◻ Other: _______________________

◻ Friend or Client _______________________________________◻ Physician: ____

*****We are honored that you have chosen Allura Skin, Laser, and Wellness Center.**
Please state the reasons for your visit:

____

____

Skin Care History:

What types of **skin care products or product line(s)** are you currently using?

____

Are you sensitive to skin care products? □ NO □ YES
If yes, is sensitivity due to: □ Fragrances □ Irritation □ Rash □ Dryness

In your opinion, what **type of skin** do you have?
□ Dry □ Normal to Dry □ Normal □ Normal to Oily □ Oily Problem/blemished

How easy is it to tan your skin?
□ Always burn □ Burn at first, but can get a light tan □ Rarely burn, always tan
□ Never burn, easily tan □ Always tan

Have you been treated for **acne with □ oral medications □ creams or □ Accutane**?

Are you currently taking Accutane? □ Yes □ No

If sexually active, what type of birth control are you using? ___________________________
Is there a possible chance you could be pregnant? _______

Have you ever been tested for **HIV** □ Yes □ No
If yes, results were □ Negative □ Positive

Have you been diagnosed with **Hepatitis?** □ Yes □ No
If yes, please check which type:
□ Hepatitis A □ Hepatitis B □ Hepatitis C □ Other

Are you currently undergoing treatment by a physician? Yes No
If yes, Physician name: ____

Have you ever had any of the following **procedures** (please check all that apply)?
Please include approximate year:
□ Body Contouring (Thermage, VaserShape, or Other): ________________________________
□ Botox/Dysport/Xeomin: ____
□ Chemical Peel____
□ Facials: ____
□ Fillers: ____
□ Fractional Lasers (Fraxel or CO2 or Sublative or Other):_____________________________
□ Hair Removal (Electrolysis, Wax or Dermablading): ___________________________________
□ IPL (intense pulse light) or FotoFacial: ____
□ Laser Hair Removal: ____
□ Microderms: ____
□ Permanent Make-Up: ____
□ Skin Tightening of Face or Eyes (Thermage or Other): ________________________________
□ Teeth Whitening: ____
□ Vein Treatment: ____

Have you had any **adverse reactions** to any of the treatments listed above? □ NO □ YES
If yes, please explain the reactions:

____

____

Medical History

Please mark if you or a family member has or has ever had any of the following conditions:

You		Condition	Family	
Y	N	Diabetes	Y	N
Y	N	Hypertension	Y	N
Y	N	Heart Disease	Y	N
Y	N	High Cholesterol	Y	N
Y	N	Stroke	Y	N
Y	N	Heart Murmur	Y	N
Y	N	Rheumatic Fever	Y	N
Y	N	A Fib	Y	N
Y	N	Phlebitis	Y	N
Y	N	Blood Clots	Y	N
Y	N	Polycythemia/hemochromatosis	Y	N
Y	N	Bleeding Disorder	Y	N
Y	N	Varicose Veins	Y	N
Y	N	Liver Disease	Y	N
Y	N	Hepatitis A__B__C__	Y	N
Y	N	Hypothyroid	Y	N
Y	N	Hyperthyroid/Graves	Y	N
Y	N	Thyroid Cancer	Y	N
Y	N	Other thyroid problems	Y	N
Y	N	Kidney Disease	Y	N
Y	N	Psychiatric Disorder	Y	N
Y	N	Depression	Y	N
Y	N	Asthma/Emphysema/COPD	Y	N
Y	N	Chronic Bronchitis	Y	N
Y	N	Leukemia	Y	N
Y	N	Lymphoma	Y	N
Y	N	Colon Cancer	Y	N
Y	N	Crohn's	Y	N
Y	N	Gluten Intolerance/Celiac Disease	Y	N
Y	N	Lactose Intolerance	Y	N
Y	N	Colon Polyps	Y	N
Y	N	Multiple Myeloma	Y	N
Y	N	Lung Cancer	Y	N
Y	N	Rectal Cancer	Y	N
Y	N	Breast Cancer	Y	N
Y	N	Prostate Cancer	Y	N
Y	N	Ovarian Cancer	Y	N
Y	N	Lupus	Y	N
Y	N	Multiple Sclerosis	Y	N
Y	N	Degenerative Disc Disease	Y	N
Y	N	Scleroderma	Y	N
Y	N	Rheumatoid arthritis	Y	N
Y	N	Osteopenia/Osteoporosis	Y	N
Y	N	Arthritis	Y	N
Y	N	Chronic Pain	Y	N
Y	N	Dementia	Y	N
Y	N	Parkinson's		

Weight _______ Height _______

Drug Allergies and Reactions:

Previous Surgeries or Procedures:

____
____
____
____
____

Hospitalizations or Treatments:

____
____
____

Current Medications:
Name and dose

____
____
____
____
____
____
____

Vitamins/supplements/herbs:

____
____

Do you take Aspirin or other anti-inflammatories on a daily basis? Y ___ N ___

Social History

Do you smoke? Y ___ N ___
If yes, number/day ____ How many years? ____
Recreational Drugs? Y ___ N ___
Do you drink Alcohol? Y ___ N ___
If yes, # per week? _____
How many days a week do you exercise? ________

Authorizations:

I consent to the taking of photographs for the purpose of documentation and future comparison.
Initial _________

I authorize the release of information to/from my primary care physician or specialist if deemed necessary for the treatment.
Initial _________

I understand that **my insurance company will not cover any of the procedures performed**.
Initial _________

Payments for all procedures or services are to be paid at the conclusion of each visit.
Initial __________

I understand that procedure packages are non-transferable.
Initial __________

I authorize that the above information is up to date and correct to the best of my knowledge.
Initial __________

Signature: ____ **Date:** _____________

Provider Signature: ____ **Date:** _________

Please initial then sign below:

I authorize that the above information is up to date and correct to the best of my knowledge.
Initial __________

Signature: ____ **Date:** ___________

Provider Signature: ____ **Date:** ____________

Thank you for completing the Health History Form!