



PLEASE TAKE A MOMENT TO COMPLETE OUR MEDICAL HEALTH HISTORY FORM

Today's Date: _____

Last Name: _____ **First Name:** _____ **MI:** _____

Nick Name: _____ **Sex (please circle one):** Female Male Transgender

Date of Birth: _____ **Age:** _____

Street Address: _____ **P.O. Box Number (if applicable):** _____

City: _____ **State:** _____ **Zip Code:** _____

Phone Numbers: Home: _____ **Cell:** _____ **Work:** _____

Preferred phone number for contact: Home Cell Work

Email Address (Please print legibly): _____

YOUR EMAIL ADDRESS IS OUR PREFERRED MEANS OF CONTACTING YOU

May we send you text appointment reminders? YES NO

May we email you for appointment reminders/medical/additional scheduling information? YES NO

...for our monthly specials/special event information? YES NO I do not wish to receive these notifications

May we send you regular mail? YES NO

May we leave you a voicemail? YES NO

May we leave a message with someone else? YES NO

Occupation: _____

Marital Status: Married Divorced Single/Never Married Widowed Living with Significant Other

Ethnicity: Caucasian (Not Hispanic or Asian) Hispanic Asian Black/African-American Other _____

Language: English Spanish Other _____

Emergency Contact Information:

Name: _____ **Relationship:** _____ **Phone:** _____

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

Name: _____ **Relationship:** _____ **Phone:** _____

Preferred Pharmacy: _____

Location: _____ **Phone:** _____

Preferred Lab: _____ **Location:** _____

Physician Name: _____ **Phone:** _____

How did you hear of Allura / who may we thank for referring you? (Please check all that apply):

Internet Magazine Newspaper Billboard Mailer Staff Member Physician Other

Allura client / Family Member / Friend: _____

Physician: _____

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

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		Y	N
Y	N	Diabetes	Y	N
Y	N	Hypertension	Y	N
Y	N	Heart Disease	Y	N
Y	N	High Cholesterol	Y	N
Y	N	Heart Murmur	Y	N
Y	N	Rheumatic Fever	Y	N
Y	N	Atrial Fibrillation	Y	N
Y	N	Stroke	Y	N
Y	N	Bleeding Disorders	Y	N
Y	N	Blood Clots	Y	N
Y	N	Polycythemia/Hemochromatosis	Y	N
Y	N	Varicose Veins	Y	N
Y	N	Leukemia/Lymphoma/MM	Y	N
Y	N	Liver Disease	Y	N
Y	N	Hepatitis A B C	Y	N
Y	N	HIV	Y	N
Y	N	Hypothyroid/Hashimoto's	Y	N
Y	N	Hyperthyroid/Graves' Disease	Y	N
Y	N	Other thyroid problems	Y	N
Y	N	Asthma/Emphysema/COPD	Y	N
Y	N	Chronic Bronchitis	Y	N
Y	N	Kidney Disease	Y	N
Y	N	Crohn's/Celiac Disease	Y	N
Y	N	Lactose/Gluten Intolerance	Y	N
Y	N	Irritable Bowel	Y	N
Y	N	Colon Polyps	Y	N
Y	N	Breast Cancer	Y	N
Y	N	Colon Cancer	Y	N
Y	N	Lung Cancer	Y	N
Y	N	Ovarian Cancer	Y	N
Y	N	Prostate Cancer	Y	N
Y	N	Rectal Cancer	Y	N
Y	N	Anxiety	Y	N
Y	N	Depression	Y	N
Y	N	Psychiatric Disorder: Bi Polar	Y	N
Y	N	Auto Immune Disorders: Lupus	Y	N
Y	N	Rheumatoid Arthritis	Y	N
Y	N	Scleroderma	Y	N
Y	N	Osteopenia/Osteoporosis	Y	N
Y	N	Arthritis	Y	N
Y	N	Chronic Pain/Fibromyalgia	Y	N
Y	N	Alzheimer's Dementia	Y	N
Y	N	Multiple Sclerosis	Y	N
Y	N	Parkinson's	Y	N

Weight: _____ Height: _____

Drug Allergies and Reactions:

Previous Surgeries or Procedures:

Hospitalizations or Treatments:

Current Medications and Doses:

Vitamins, Supplements and Herbs:

Do you take Aspirin or other anti-inflammatories on a daily basis? YES NO

Social History:

Do you smoke? YES NO
If yes, number per day ____ How many years? ____
Recreational drug use? YES NO
Do you drink Alcohol? YES NO
If yes, number of drinks per week? ____
How many days per week do you exercise? ____

Patient Signature

Date

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TODAY'S DATE: _____

SYMPTOM	Frequent	Rare	Never	SYMPTOM	Frequent	Rare	Never
Anxiety				Memory Loss			
Decrease in energy/fatigue				Muscle and/or Joint pain			
Decrease in sex drive				Mood Swings			
Depression				Night Sweats			
Difficulty concentrating				Pain with Intercourse			
Fogginess in thinking				Sleep Disturbance			
Headaches/Migraines				Urine Leakage			
Hot Flashes/flushes				Vaginal Dryness			

Which sexual orientation best describes you?
 Heterosexual Homosexual Bisexual

Number of Pregnancies: _____
 Number of Live Births: _____ Miscarriages: _____
 Number of Vaginal births: _____ C/Sections: _____

Are you currently sexually active? YES NO
 If yes, what type of birth control do you use?

If no, have you ever been sexually active? YES NO

Have you ever been treated for any of these infections?
 Please check all that apply:
 Bacterial Vaginitis Chlamydia Condyloma
 Gardnerella Gonorrhea Herpes
 HIV PID Syphilis
 Yeast Warts Other _____

Date of last Pap Smear: _____
 Was it normal? YES NO
 If NO, how was it treated? _____

Have you ever had any of the following cancers?
 Breast YES NO Date & Treatment: _____
 Cervical YES NO Date & Treatment: _____
 Ovarian YES NO Date & Treatment: _____
 Uterine YES NO Date & Treatment: _____

Have you ever been tested for the BRCA gene?
 YES NO Results: _____

Have you ever had a Mammogram? YES NO
 Date of Last Mammogram: _____
 Was it normal? YES NO
 If NO, describe treatment: _____
 Do you perform self-breast exams? YES NO
 If YES, number of times per month: _____

Have you ever had a Bone Density test? YES NO
 If YES, the results were:
 Normal Osteopenia Osteoporosis _____

If you are still having periods, are they regular? YES NO
 If you no longer have periods, please check the reason:
 Natural Hysterectomy Ablation Medications
 When was your LAST menstrual period? _____

Have you ever been on Hormone Replacement Therapy?
 YES NO
 If YES, when and what kind of therapy did you receive?

Have you ever been told that you have any of the following?
 Check all that apply:
 Endometriosis Fibrocystic Breasts
 Fibroid Uterus Ovarian Cysts
 PCOS Uterine Polyps
 Describe treatments for any of the above: _____

Do you currently have any of these symptoms?
 Check all that apply:
 Acne Facial Hair Hair Loss
 Fluid Retention Melasma Rosacea
 Weight Loss Weight Gain

Do you have any other concerns that you would to discuss with your provider?

 Patient Signature Date

 Provider Signature Date



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TODAY'S DATE: _____

AUTHORIZATIONS (Please initial):

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

_____ I authorize the release of information to/from my Primary Care Physician or Specialist if deemed necessary for the treatment.

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

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

_____ I understand that procedure packages are non-transferable.

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

Client Signature (Parent/Guardian if client is a minor): _____ Date: _____

Provider Signature: _____ Date: _____

Thank you for completing this paperwork!