Medical History

Last Name:_____ First Name_____

Address:_____

City:_____ State:_____ Zip Code:_____

Date of Birth:_____/_____/_____ Sex:_____

Home Ph: (_____)_____ Cell: (_____)_____

Work Ph: (_____)_____ E-mail:_____

Family Doctor:_____ Phone: (_____)_____

Pharmacy:_____ Phone: (_____)_____

How did you hear about us?_____

Please answer all of the following questions:	YES	NO
1. Do you have any current or chronic medical illness we should know about? Please list:	☐	☐
2. Are you currently under a doctor's care? If so, for what reason?	☐	☐
3. Do you take/use ANY medications, herbs/natural supplements or topicals on a regular or daily basis? Please list:	☐	☐
4. Do you have ANY allergies to medications, foods, latex or other substances? Please list:	☐	☐

Ten20
10 years younger in Twenty minutes

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