CANYON VIEW wellness & spa

Medical History Form

Name: _____ Birthdate:_____Today's Date_____

Reasons for visit: (Please describe why you are here and any services you are interested in)

Allergies: (list any medications you are allergic to and reaction you had.)

I am allergic to: _____ My reaction was:_____

____ I have no allergies to medications

Past Medical History: (Mark any of the following that you have been diagnosed or treated for)

____Allergic to latex or rubber	____Attempted suicide	____High Blood Pressure
____Stroke	____Hepatitis or liver disease	____Acne
____Thyroid disease	____Asthma	____HIV positive
____Problems with local Anesthetic	____Drugs or Alcohol addiction	____High Cholesterol
____Depression	____Gallbladder disease	____Easy bruising
____Cancer	____Pneumonia	____Sexually transmitted infections
____Problems with general Anesthetic	____Diabetes	____Migraines
____Anxiety/Panic disorder	____Ulcer	____Skin cancer
____Osteoarthritis	____Tuberculosis	_____ Coldsores/ Herpes/ Fever blisters
____Anemia	____Chemotherapy Treatment	____Epilepsy/Seizure
____Mental illness	____Bowel disease	____Autoimmune disorder
____Osteoporosis	____Heart disease	____Genital or facial wart
____Bleeding Disorder	____Radiation treatments	____Kidney/bladder disease

Do you have any other health problems?

Are you on any blood thinners (Coumadin, aspirin, etc.)? Yes No

Do you have a pacemaker? Yes No

Do you wear contact lenses? Yes No

Past Surgical History:

Year: _____ Type of Surgery: _____

Year: _____ Type of Surgery: _____

Year: _____ Type of Surgery: _____

Hospitalizations: (exclude above surgeries)

Year: _____ Reason for Hospitalization: _____

Year: _____ Reason for Hospitalization: _____

Female Patients:

Total number of pregnancies: _____ Deliveries: _____

Are you currently pregnant or breast feeding? Yes No

Do you have periods? Yes No Date of last period: _____

Have you gone through menopause? Yes No

Are you interested in learning more about hormone replacement? Yes No

Medications and supplements: (currently taking)

Medication: _____ Dosage: _____Number of daily doses: _____

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Medication: _____ Dosage: _____ Number of daily doses: _____

Habits:

Tobacco use: yes No I smoke _____ cigarettes/cigars/pipe/ day

Drug use: yes No _____

Alcohol use: yes No I drink _____glasses/day/week

Caffeine use: yes No I drink _____ cups/day/week

Exercise: all the time sometimes rare

Healthy Diet: yes No

Water intake: _____glasses/day

Botox History:

Have you had Botox injections before? _____ If yes when was your last injection? _____

Have you been happy with your results? _____ Have you had any complications with Botox (eyelid/eyebrow droop)? _____

Explain: _____

Any special concerns? _____ What areas would you like treated today? _____

Dermal Filler History:

Have had any Dermal Filler procedures before? _____ If yes, what filler was used and were you satisfied with the results?

_____

Have been Collagen Tested _____ Date _____ Were there complications? _____

Skin History:

Conditions you would like to improve:

_____ wrinkles _____ Pigmentation problems _____ Acne _____ Acne scars _____ Cellulite

_____Sagging skin _____ Dry skin

Sun Exposure:	**Tanning Beds:**	**Sunscreen:**
Past : ___ Little ___ Excessive	Past: ___ Little ____ Excessive	___never ____ occasional ___Daily
Present: ___ Little ____Excessive	Present: ___ Little ____Excessive	

Yes	**No**	**Have you ever had or used:**
____	____	Retin A
____	____	Chemical peel
____	____	Microdermabrasion
____	____	Laser, type_____
____	____	Botox, date _____
____	____	Restylane, date _____
____	____	Collagen or other tissue filler
____	____	Accutane, last used: _____
____	____	Herpes medication
____	____	Antibiotics for skin
____	____	Oral contraceptives
____	____	Topical Steriods

Current skin care regimen:

Cleanser: _____

Toner: _____

Exfoliator: _____

Moisturizer: _____

Sunscreen: _____

Other: _____