WELLNESS FOR LIFE
HEALTHY AND STRONG FROM THE INSIDE OUT

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At Wellness for Life, we believe that your healthcare is one of the most important things in your life and that it is not up to the profitability of an insurance company to decide what you do and do not need. We are happy to give you the documentation you need to get reimbursed from your insurance company. **By signing, you acknowledge you understand we do NOT directly interact with your insurance company and that you cannot have a refund for our services because you later decide to try to get reimbursed from your insurance.**

Patient Health History Form

Name: Date of Birth: Age:

Address:

Phone: May we leave a voicemail? May we text you?

Email: May we email you?

How did you hear about us?

Emergency Contact Name/Number/relationship:

What pharmacy do you like to use?

Do you have Medicare benefits?

I certify that all the medical and personal history statements, given in this document are true and correct. I am aware that it is my responsibility to inform the staff members 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 procedure. My signature acknowledges consent to treat.

Signature:

Date:

What is your number one health goal?

Do you have any health problems or medical conditions? Please list and what therapies/medications you are using:

Please list ALL allergies you may have (medicines, food, pollen, etc.) and briefly describe your reaction (i.e. rash, hives, shortness of breath, etc.). If no allergies, please write NONE:

Please list any herbs/supplement you take. Please include the dose and the frequency:

Please check the following:	I smoke	□ NO □ YES How much per day?
	I drink alcohol	□ NO □ YES How much per day?
	I use drugs not prescribed for me	□ NO □ YES How much per day?

Please check the following:	Any active infection?	□ NO □ YES
	Are you pregnant?	□ NO □ YES
	Any major illness or hospitalization within the last 5 years?	□ NO □ YES
	If female, do you have a gynecologist?	□ NO □ YES

If you are interested in aesthetics/skin care, please fill out the next section (If not, you are done!)

Which of the following best describe your skin type?

I	Always burns, never tans
II	Always burns, sometimes tans
III	Sometimes burns, always tans
IV	Rarely burns, always tans
V	Brown, moderately pigmented skin
VI	Extremely dark skin

Do you have a history of facial trauma? Is so, what?

Are you currently using, or have you used any of the following medications within the last 6 months?

□ Accutane □ Retin-A □ Tretinoin □ Isotreintoin
□ Tetracycline □ Griseofulvin □ Ciprofloxacin □ Naproxen □ Amiodarone □ Thiazides

Please check the following:	Complications from any laser or light treatments?	□ NO □ YES
	Complications from any cosmetic procedures?	□ NO □ YES
	Form thick or raised scars from cuts or burns?	□ NO □ YES
	Hyperpigmentation (darkening of the skin)?	□ NO □ YES
	Hypopigmentation (lightening of the skin)?	□ NO □ YES
	Recent use of self-tanning lotion, tanning or sun exposure?	□ NO □ YES

At Wellness for Life, we are always interested in providing services that will make you feel fantastic! Please tell us if you would be interested in scheduling a consultation for (circle please):

Botox/Filler/Kybella (double chin reduction)/Stem Cell (PRP/PRFM)/Microneedling either with serum or stem cells/Facials/Advanced Exfoliation(peels)/Rosacea Treatment/Acne Treatment/Melasma Treatment/Microblading/Lip Blushing/permanent eyeliner/lashes/brow work