HEALTH & AESTHETICS LLC

Medical History Form

Name_____SS#_____Date_____

Address_____ City, ST, Zip_____

Email _____Phone (Home) _____ Date of birth_____

Company / Occupation _____ Insurance Carrier _____

Current Medications

It is required by the state of Tennessee that all patients be looked up on the database. Please list all current medications you are presently taking or have had filled by a pharmacy in the last 30 days.

_____
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Medical History

○ Headache	○ Lactose Intolerance	○ Depression
○ Shortness of Breath	○ Gallbladder disease	○ Gout
○ Heart Palpitations	○ Prostate Disease	○ Scarlet Fever
○ Heart Murmur	○ Bowel Irregularity	○ Chronic Rashes
○ Chest Pain	○ Incontinence	○ Rheumatic Fever
○ Dizziness/ Fainting	○ Sexual Dysfunction	○ Mumps
○ Vascular Disease	○ Venereal Disease	○ Measles
○ Allergies/ Hay Fever	○ Frequent Infections	○ Rubella
○ Asthma	○ Hepatitis	○ Polio
○ Bronchitis	○ Anemia	○ Diphtheria
○ Pneumonia	○ Arthritis	○ Tetanus
○ Ulcer	○ Osteoporosis	○ Other
○ GI Disorders	○ Nervousness	○ Other

Drug Allergies: _____

Women Only: Pregnant? Y__ N__ Planning Pregnancy? Y__ N__ Last Period_____ Last Mamogram_____

Habits: Smoke: __Y__N Packs daily_____ |Alcohol: __Y__N Amount_____ | Caffeine: __Y__N How much? _____

Exercise Routine: _____
What is your Diet like now: _____
_____

Release of Liability: By providing my signature below, I certify that the medical information I provided on this form is true to the best of my knowledge. I am not pregnant or breastfeeding at this time, and should I become pregnant, I will immediately stop this medication and inform my healthcare provider of my condition. I am aware that the provider here is not my personal medical provider and is generally not on-call for emergency purposes. Furthermore, I acknowledge that in the last 6 months I have received blood tests that include GBC, Glucose level, Thyroid panel, Lipid panel, Potassium level, and Renal function test. I am not aware of any abnormalities on any of these tests and I have not been instructed by my Primary Care Provider or any other medical specialist to refrain from a weight loss medication. I give my full consent for this clinic from any liability and its providers and employees from any and all injuries and losses that I may sustain as a result of any misrepresentation that I made in my medical history and/or physical exam. In addition, my consent allows my blood to drawn and tested for but not limited to HIV and Hepatitis, in the event of a needle stick. I understand that this release of liability is ongoing until such time that I make necessary corrections.

☐ Check here if you do not want to receive to receive emails from Health & Aesthetics with Coupons, Specials and New Product Notices.

Signature: _____ Date: _____