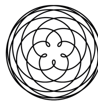


AGELESS YOUTH
by Renata

BRIEF MEDICAL HISTORY AND INFORMED CONSENT

First and Last Name: ____

Date of Birth (mm/dd/year): ______________________ Age: _________ Sex: _________

Gender: ___________ Pronouns: _____________ Height: _________Weight: _________

Cell Phone Number: ____

Address: ____

City/State: ____ Zip Code: ____________

Email: ____

Emergency Contact: ____

How did you find out about us? ____

Allergies: ____

What medications are you currently taking with dosages, when was taken last time?

____

Are you pregnant/trying to get pregnant or lactating? ______________________________

Your Primary Physician's Name: ____

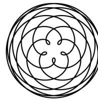
Circle any of the following illnesses you have or have ever had in the past:

Myasthenia Gravis
Hepatitis
Eye Disease
Autoimmune Disease
Vision Problems
Numbness
Muscle Weakness
Cancer
Herpes
Frequent Cold Sores
Amyotrophic Lateral Sclerosis (ALS)
Eaton Lambert
Disorder Seizures
Thyroid Imbalance
Blood Clotting Abnormalities
Diabetes
Arthritis
Keloid Scarring
Hypertension
HIV/AIDS
Any Active Infection
Hormone imbalance
Skin Diseases

Explain: ____

Any surgeries/dental procedures within last 12 months? ___________________________

Any previous hospitalizations/operations: _______________________________________



AGELESS YOUTH
by Renata

I understand the information on this form is essential to determine my medical and cosmetic needs and the provision of treatment. I understand that if any changes occur in my medical history/health, I will report it to the office as soon as possible. I have read and understand the above medical questionnaire. I acknowledge that all answers have been recorded truthfully and I will not hold any staff member responsible for any errors or omissions that I have made in the completion of this form.

Patient Signature: ____

Today`s Date: ____