skin & body CLINIC
3780 B, Foothills Rd. • Las Cruces, NM 88011 • (575)222-0900 • www.annasmedspa.com

Medical History

Name: _____

Referred by: _____

Date of Birth: _____ Ht: _____ Wt: _____

Occupation: _____

Home # : _____ Cell # : _____

E-mail address: _____

Address: _____City/State: _____ Zip: _____

Current Medications: (Including any prescriptions, over-the-counter meds, herbal remedies, etc…)

_____

_____

Allergies/Adverse Reactions: _____

Women: Are you Pregnant or Lactating? Yes No LMP: _____

Primary Care Provider/Physician: _____

Previous Hospitalizations/Operations:

_____

_____

_____

Current Skin Care Products/Practices:

_____

_____

_____

Current Skin Care Challenges/ Reason for Visit Today:

_____

_____

_____

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Circle any of the following illnesses you have or have ever had in the past:		
Myesthenia Gravis	Liver/Kidney/Gall Bladder/Thyroid/Autoimmune Disorders	Cancer
Eaton Lambert/ Amyotrophic Lateral Sclerosis (ALS)	Active Arthritis/Arthralgias	Allergy to Albumin/egg
Unexplained Numbness/Muscle Weakness	Vision Problems/ Eye Disease	Alcoholism
History of Anaphylaxis	Asthma/Chronic Cough	Cardiac Disease
High Blood Pressure/ Stroke	Anemia or Other Bleeding/Clotting Blood Disorders	Defibrillator/Pacemaker
Immunosuppressive Therapy	Metal Implants	Headaches/Epilepsy/Seizures
Hazardous Work/Recreational Activities:	Chronic Conditions- Gout, Pain, Constipation, Diarrhea, Dizziness, Ulcers, Seasonal Allergies Other:	Acne/Eczema/Dermatitis/Rashes/ Herpes or Other Skin Disorders:

Additional Information (including most recent aesthetic procedures/injections):

_____

_____

_____

Describe Your Typical Meal/Eating Habits:

Breakfast	Lunch	Dinner
_____	_____	_____
_____	_____	_____
_____	_____	_____

USUAL Snacks:

_____

How much water do you drink per day? _____
Currently Dieting? NO YES
Which one? _____
Ideal/Desired weight: _____
Describe your usual energy level: very low - low - moderate/ medium - high - very high
Do You Smoke? NO YES How Much? _____ For How Long? _____
Do You Use Sunscreen? NO YES Do You Tan/Use Tanning Products? YES NO
Do You Drink Alcohol? NO YES How Much? _____
Do You Drink Caffeinated Beverages? NO YES How Much? _____
Do you take nutritional supplements? NO YES _____
Do You Exercise Regularly? NO YES How Often? _____

I understand the information on this form is essential to determine my medical and cosmetic needs and to develop my personalized treatment plan.

I understand that if ***any changes occur in my medical history and/or health I will report it as soon as possible***.

I have read, understand and acknowledge that all answers have been recorded truthfully.

I will not hold the clinic or its staff responsible for any errors or omissions that I have made in the completion of this form.

I have been made aware that all my medical information will be kept confidential.

_____ _____

Client Signature **Date**

_____ _____

Parent Signature (if under 18) **Date**

_____ _____

Clinician Signature **Date**