VENUS VERSA

MEDICAL HISTORY

Client Name: ______________________ Client ID #: ______________

Date of Birth (mm/dd/yy): ______ / ______ / ______ Height: __________ Weight: __________

Address: ______________________ City: ______________

State/Province: ______________ Zip/Postal Code: __________ Country: __________

Home Phone: __________ Work Phone: __________ Cell Phone: __________

Can I leave a message at: ❒ Home ❒ Work ❒ Cell ❒ Email: ______________________

Health Card No. (& Version Code): ______________________ Occupation: ______________

Emergency Contact Name and Number: ______________________

Referred By: ______________________

There exists a risk if our staff is not aware of the general health and medical background of a client. This information may critically affect what procedure we may recommend or safely undertake. Please provide us with the following information and keep it updated.

Please circle all of the following medical conditions you now have or have had in the past. **If you have had none, please circle "none of the above".**

bleeding tendency / diabetes / blood transfusions / glaucoma / dry eyes / lung disease / TB / asthma or wheezing / emphysema / bronchitis / irregular heartbeat / chest pain / heart disease / high blood pressure / pacemaker / heart attack / stroke / epilepsy / heart burn / intestinal ulcers or bleeding / rheumatoid arthritis / scleroderma / lupus / porphyria / depression / mental illness / drug or alcohol addiction / hepatitis B / hepatitis C / HIV / contact lenses / loose or chipped teeth / dentures / dental implants / veneers / caps / **none of the above / any other serious illness or injury (please explain):**

____

Please list all medications that you are currently taking or have used in the past 6 months. **Use the back of page if necessary.**

Medication(s)	Amount	Frequency

Please list all naturopathic, health food supplements, and vitamins:

____

____

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Please list all **ALLERGIES** (including **latex**): ____________________

____

Are you a smoker: ❒ Yes ❒ No If you are an ex-smoker, how long have you been smoke-free? ____________________

How much are (were) you smoking? ____________________ For how long: ____________________

How much alcohol do you drink per week? ____________________ Caffeine per week? ____________________

Is there any possibility that you may be pregnant at this time? ❒ Yes ❒ No

Do you have a history of cold sores? ❒ Yes ❒ No If yes, when was your last outbreak? ____________________

Do you or your family have a history of atypical moles, vitiligo, developing keloids, melanoma, or skin cancer? ❒ Yes ❒ No

If yes, please circle which and explain: ____________________

Please list all surgeries that you have had (include plastic surgery and wisdom teeth removal) with the date you had the surgery:

____

____

Have you or anyone in your family ever had, or currently have, a history of unusual reactions or problems with **LOCAL** anesthesia (e.g. dental freezing), **TOPICAL** anesthesia (e.g. anesthetic creams or gels) resulting in rashes, muscle weakness, jaundice, breathing problems, and/or unexpected fever(s)? ❒ Yes ❒ No

If yes, please explain: ____________________

I acknowledge that I have disclosed my complete medical history and the above is a complete and accurate representation of my medical and psychological status. I, ____________________, represent to the physicians and staff that I am at least 18 (eighteen) years of age or, if not, am accompanied by a legal guardian. I hereby consent to and authorize a history examination by my doctor and such assistant or staff as may be assigned by him/her.

If appropriate, I authorize the release of any medical information for the purpose of processing insurance claims on my behalf. I authorize payments of medical benefits directly to the doctor for services provided to me. A copy of this authorization shall be considered as valid as the original. I understand that photography is a necessary part of planning and evaluating cosmetic procedures. I authorize the taking of photographs at the direction of my physician or physician delegate and under such conditions as may be approved by him/her. These photographs will be used solely for documentation purposes and will be kept confidential unless otherwise disclosed.

I understand that there is a consultation fee for the initial visit, which is due at the time of my appointment unless other arrangements have been made in advance.

SIGNATURE: ____________________ **DATE:** ____________________

RELATIONSHIP: (circle one) **PATIENT SPOUSE PARENT GUARDIAN**

VENUS VERSA

MEDICAL HISTORY – UPDATES

Client ID #: ____________________

Date:	Client Initials:	Date:	Client Initials:
Date: ________	Client Initials: ________	Date: ________	Client Initials: ________
Date: ________	Client Initials: ________	Date: ________	Client Initials: ________
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