ADULT MEDICAL HISTORY QUESTIONNAIRE | PATIENT INFORMATION

Patient Name:____**Date of Birth:**__________________

Home Address:____

City:________________________________ State:___________ Zip:___________________________

Home Phone:____________________ Work Phone:________________ Cell Phone: ____________

Email Address:____

Emergency Contact:

Name:_________________________ Phone:_____________________ Relationship:____________

How were you referred to us?____

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE WILL BE KEPT STRICTLY CONFIDENTIAL.

Main reason for today's visit:____

Other Concerns:____

TREATMENTS THAT INTEREST YOU

Please put a check mark next to the services that interest you.

- ◻ Primary Care
- ◻ Weight Loss
- ◻ Hormone Replacement
- ◻ Peptide Therapy
- ◻ Ozone Therapy
- ◻ Cellulite Reduction
- ◻ Neutraceuticals
- ◻ Botox
- ◻ Dermal Fillers
- ◻ Skin Resurfacing
- ◻ Chemical Peel/Facial
- ◻ Acne Treatments
- ◻ RF Microneedling

MEDICATIONS:

Please list all medications you are taking. Include prescribed and over the counter drugs, such as vitamins/inhalers, etc.

Drug Name: Strength: Frequency Taken:

Allergies: Reaction:

PAST MEDICAL HISTORY: Please check all that apply:

- ◻ Anxiety Disorder
- ◻ Arthritis
- ◻ Appendicitis
- ◻ Asthma
- ◻ Bleeding Disorder
- ◻ Blood Clots (or DVT)
- ◻ Cancer:
  Type(s):___________
- ◻ Coronary Artery Disease
- ◻ Diabetes - Insulin
- ◻ Diabetes - Non-Insulin
- ◻ Dialysis
- ◻ Diverticulosis/Diverticulitis
- ◻ Fibromyalgia
- ◻ Gallstones
- ◻ Gout
- ◻ Heart Attack
- ◻ Heartburn
- ◻ Heart Murmur
- ◻ Hiatal Hernia
- ◻ Hepatitis
- ◻ HIV or AIDS
- ◻ High Cholesterol
- ◻ High Blood Pressure
- ◻ Kidney Disease
- ◻ Kidney Stones
- ◻ Leg-Foot Ulcers
- ◻ Liver Disease
- ◻ Osteoporosis
- ◻ Pacemaker
- ◻ Peptic Ulcer Disease
- ◻ Pulmonary Embolism Stroke
- ◻ Thyroid Disorder
- ◻ Tuberculosis
- ◻ Other:___________________

PAST SURGICAL HISTORY:

Type of Surgery

1. ______________________________ Date:______________
2. ______________________________ Date:______________
3. ______________________________ Date:______________
4. ______________________________ Date:______________

FAMILY HEALTH HISTORY:

If any of the following family members have been diagnosed with Cancer (if so, what type), Diabetes, Heart Disease, Hypertension, or any other major disease/illness, please fill in the following:

	Disease(s)/Illness:
Mother	______________________
Father	______________________
Maternal Grandmother	______________________
Maternal Grandfather	______________________
Paternal Grandmother	______________________
Paternal Grandfather	______________________
Sibling (Circle): Brother/ Sister	______________________
Sibling (Circle): Brother/ Sister	______________________
Sibling (Circle): Brother/ Sister	______________________
Sibling (Circle): Brother/ Sister	______________________

IMMUNIZATION HISTORY:

□ Chickenpox	Date:__________	□ Meningcoccus	Date:__________
□ Flu Shot	Date:__________	□ MMR (Measles, Mumps, Rubella)	Date:__________
□ Gardasil/HPV	Date:__________	□ Pneumonia (Pneumovax)	Date:__________
□ Hepatitis A	Date:__________	□ Tdap (Tetanus/Diptheria/Pertussis)	Date:__________
□ Hepatitis B	Date:__________	□ Zostavax (Shingles)	Date:__________

(WOMEN ONLY) OBSTETRIC AND GYNECOLOGICAL HISTORY: Please Check All That Apply

Last PAP Smear Date:________________ □ Abnormal
Last Mammogram Date:_______________ □ Abnormal
Age of first menstrual period: ____________________
Date of last menstrual period or age of menopause:______
Do you get your period monthly? □ Yes □ No
Flow: □ Light □ Moderate □ Heavy

Current Birth Control Method: _____________________
Number of Pregnancies:_____ Abortions:__________
Miscarriages:______ Births:________

□ Bleeding between periods
□ Extreme menstrual pain
□ Vaginal itching, burning, or discharge
□ Wake up in the night to go to the bathroom
□ Hot flashes
□ Breast lump or nipple discharge
□ Painful intercourse

SOCIAL HISTORY:

Occupation:____

Marital Status: □ Married □ Single □ Divorced □ Separated □ Widowed □ Domestic Partner

Sexually Active: □ Yes □ No

Do you use condoms? □ Yes □ No

Interested in being screened for STD's □ Yes □ No

Exercise Level: □ None □ Occasional □ Moderate □ Heavy

Stress Level: □ None □ Occasional □ Moderate □ Heavy

Smoking: □ Yes □ No If yes, # of packs per day? ______ Per Week?_______

Smoked Since Age: __________

Alcohol: □ None □ Occasional □ Moderate □ Heavy

Caffeine: □ None □ Occasional □ Moderate □ Heavy

Chewing Tobacco: □ None □ Once a day □ 2 - 4 Times a day □ 5+ Times a day

Drugs: Do you currently use recreational or street drugs? □ Yes □ No

If yes, please list:____

SIGNATURE

I certify that the preceding medical and personal history statements are true and correct. I am aware that it is my responsibility to inform that practitioner of my current medical or health conditions and to update this history. A current medical history is essential for the provider to give the best care and execute appropriate treatment procedures.

Signature:____ Date:____________________

Your Health District Policies

Appointment Policy
We ask that you please arrive 10-15 minutes prior to your appointment time. We will do our best to accommodate late arrivals. However, the length of service may be adjusted so as to not interrupt the scheduled appointments of other patients.

Payment is due in full when services are rendered. We accept all major credit cards, debit cards, and cash.

Balances owed: Balances owed must be paid prior to receiving any further services.

Cancellation Policy
Your treatments are reserved especially for you. We value your business and ask that you respect Your Health District's (YHD) scheduling policies. If you need to cancel or reschedule, please notify us at least 24 hours in advance. Any cancellations with less than 24 hours of notice are subject to a cancellation fee of $25. Clients who no show for appointments without giving any prior notification are subject to pay up to 50% of the scheduled service. When you schedule your appointment with us, you are agreeing to these policies.

Refund Policy Injectables
All injectable treatment sales (Botox, Juvederm, Radiesse, Restylane, Sculptra and others) are final; refunds or credits cannot be offered once treatment is completed.

Treatments & Packages
Once services are purchased they will not be refunded, however, to ensure our clients always receive the greatest experience at YHD, unused service values (cash equivalent for the remaining amount of a treatment package) can be applied to any other service at YHD. To avoid abuse of special discounting with treatment/service packages, refunds on remaining un-used treatments will be given only after applying the full standard price of used treatments. All service packages and pre-paid treatments must be used within 12 months of date of purchase or they will expire.

Clients who have purchased our services from third parties (Groupon, LivingSocial, etc.) need to check the third party voucher for terms and conditions, as the terms or conditions of the deal/voucher will apply. Since third party entities are paid directly by the client, YHD cannot refund purchases made via a third party. However, notwithstanding the voucher terms of any third party, patients who are unsatisfied with the purchase, may redeem the remaining unused portion of the voucher for another service currently offered at YHD. Services that have already been rendered will not be redeemed again.

All prices, policies and services are subject to change without notice.

Products
We are constantly striving to create an environment founded in excellence, quality, and most importantly - the safety of our clients. For this reason, we cannot accept product returns (with exception to dear defects in packaging or product) once your purchase has been completed.

Gift Certificates
Gift certificates are non-refundable. We will, however, allow them to be transferred to another party.

Patient Signature:____ **Date:**_______________