



MEDICAL HISTORY QUESTIONNAIRE | PATIENT INFORMATION

Patient Name: _____ **Date of Birth:** _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Personal 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.

Reason for today's visit: _____

TREATMENTS THAT INTEREST YOU

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

- | | |
|----------------------------------------------|-----------------------------------------------------------------------|
| <input type="checkbox"/> Primary Care | <input type="checkbox"/> Neurotoxin Injections (Botox/Xeomin/Dysport) |
| <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Dermal Fillers |
| <input type="checkbox"/> Hormone Replacement | <input type="checkbox"/> Skin Resurfacing |
| <input type="checkbox"/> Peptide Therapy | <input type="checkbox"/> Chemical Peel/Facial |
| <input type="checkbox"/> Ozone Therapy | <input type="checkbox"/> Acne Treatments |
| <input type="checkbox"/> Cellulite Reduction | <input type="checkbox"/> RF Microneedling |
| <input type="checkbox"/> Neutraceuticals | <input type="checkbox"/> Laser Hair Reduction |

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:

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

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:

- | | | | |
|---------------------------------------|-------------|--------------------------------------------------------------|-------------|
| <input type="checkbox"/> Chickenpox | Date: _____ | <input type="checkbox"/> Meningococcus | Date: _____ |
| <input type="checkbox"/> Flu Shot | Date: _____ | <input type="checkbox"/> MMR (Measles, Mumps, Rubella) | Date: _____ |
| <input type="checkbox"/> COVID | Date: _____ | <input type="checkbox"/> Pneumonia (Pneumovax) | Date: _____ |
| <input type="checkbox"/> Gardasil/HPV | Date: _____ | <input type="checkbox"/> Tdap (Tetanus/Diphtheria/Pertussis) | Date: _____ |
| <input type="checkbox"/> Hepatitis A | Date: _____ | <input type="checkbox"/> Zostavax (Shingles) | Date: _____ |
| <input type="checkbox"/> Hepatitis B | 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: _____

Births: _____ Miscarriages: _____ Abortions: _____

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

Nicotine Products: 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

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

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.

Please read and initial the following policies:

_____ **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. **BALANCES UNDER \$50 WILL AUTOMATICALLY BE PAID USING THE CARD ON FILE.** It is the patient's responsibility to ensure YHD has the proper card on file.

_____ **Cancellation Policy:** Your appointments 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.

_____ **Insurance:** YHD will bill your insurance as a courtesy. It is the patient's responsibility to understand coverage and benefits. YHD cannot guarantee coverage of your insurance claim or any specific insurance payment amounts.

_____ **Lab Services:** The physician may order laboratory services for you while you are in our facility. Although the samples are collected in this facility, we send them to a third party lab (i.e. Lab Corp, Sonora Quest, etc.). The lab is responsible for all claims and billing to your insurance company. It is the patient's responsibility to understand their benefits, coverage and deductibles. YHD cannot guarantee coverage of your insurance claim or any specific insurance payment amounts.

_____ **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. Gift certificates are non-refundable. We will, however, allow them to be transferred to another party. All injectable treatment sales are final; refunds or credits cannot be offered once treatment is completed.

_____ **Third Party Purchases:** 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.

_____ **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 defects in packaging or product) once your purchase has been completed.

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

Patient Name (Print): _____ **Date:** _____

Patient Signature: _____