

The Medical Spa

@ GMG

Name: _____ Birth Date: _____

Address _____

City _____ State _____ Zip Code _____

Social Security Number: _____ Male / Female

Phone Number: _____ Alt. Phone Number: _____

Family/Primary Doctor: _____

Email Address: _____

Past Medical History

Check all that apply and add any pertinent information.

- Diabetes Mellitus Last Hgb A1C _____
- Hypertension
- Elevated Cholesterol
- Heart Condition
- Coronary Artery Disease
- Congestive Heart Failure
- Arrhythmias
- Valvular Heart Disease
- Myocardial Infarction
- Stroke or other neurological condition
- Gallbladder Disease or Gallstones
- Liver Disease
- Peptic Ulcer Disease
- Kidney Disease
- Thyroid Disease
- Asthma Emphysema Chronic Bronchitis
- Blood Clots
- Cancer
- Anxiety Depression Other Psychiatric Disorder
- Bone Fracture in the last 6 months
- Pregnant or intend to become pregnant in the near future
- Breastfeeding
- Other Medical Condition not listed above

Past Surgical History: List all prior surgeries and dates.

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Allergies

List all prescription or over-the-counter medication or food allergies and reactions that you have had to these products.

Medications

List all prescriptions and over-the-counter medications and doses.

Social History

Marital Status _____

Children _____

Occupation _____

Tobacco Use _____

Alcohol Use _____

Illicit/Recreational Drug Use _____ (Information strictly confidential)

Family History

If applicable, note medical problems and degree of obesity.

Father _____

Mother _____

Siblings _____

Diet & Exercise History

List diet programs and approaches used in the past:

List prescription and over-the-counter diet medications used in the past:

What is your present activity level and exercise routine?
