Vitality Anti-Aging Center
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Vitality Anti-Aging Center

Medical History Form

Name:____________________________ Date of Birth________________________________

Section 1 : Medication/Surgical/Anesthesia history

Current Medications/ Dosage/frequency:

____
____
____
____

Allergies/Reaction:

____
____

Ever had problems with Anesthesia: Yes/No

Describe reaction:____

Women Only:

Are you pregnant: Yes/no Nursing: Yes/No Try to become pregnant: Yes/No

# of Pregnancies_______ Miscarriages:________ Abortions_________

Date of last period: Birth control Method:

Last PAP: Last Mammogram:

Section II: Personal Medical History

Have you or do you have: (circle all that apply)

Asthma
Anxiety
Anemia
Arthritis
Cancer: Type________
High Cholesterol
Emphysema
Epilepsy/seizure
Heart attack
Heart Disease

Thyroid Issues
Infertility
Prostate problems
Migraine
Glaucoma
Diabetes
Multiple Sclerosis
Myasthenia Gravis
Lupus
Attention Deficit Disorder

High blood Pressure
Kidney disease
Stroke
Hernia
Fibromyalgia
Sleep Apnea
Depression
Bladder leakage
Cold sores
GERD/Reflux
Abnormal PAP
Skin Rashes

Section III: Family History

Has anyone in your immediate family had or has: (Parents, Grandparents, Siblings, Children)
Please list the relationship of the person with the disease.
Cancer: Type/who

____

Bleeding Disorder____
Heart Disease/ Heart attack____
High Blood Pressure____
Thyroid Disease____
Diabetes____
Depression____
Stroke____
Tuberculosis____
Mental Illness____
Asthma____
Obesity____
High Cholesterol____
Autoimmune Disease____

Present Age or age at death		If living, Health (Good, Fair, Poor)	If deceased, cause of death
Mother:	_________	____________________________	_______________________
Father:	_________	____________________________	_______________________
Brother/Sisters:	_________	____________________________	_______________________

Section IV: Social History

Do you smoke: Yes☐ No☐ # packs per day______
Do you Drink Alcohol: Yes☐ No☐ How often: Daily☐ Weekly☐ Occasional☐
Do you use illicit drugs: Yes☐ No☐
Do you wear your seatbelt: Yes☐ No☐
Do you exercise Regularly: Yes☐ No☐ How often?________ Type of Exercise_____________
Please circle the following foods in your diet:
Grains and Starches: A lot Some Few
Vegetables/Fruit: A lot Some Few
Dairy: A lot Some Few
Meats: A lot Some Few
Sugar/Sweets: A lot Some Few
How much time do you spend in the sun?________ Tanning Booth_____________
Do you use SPF: Yes☐ NO☐ How often__________ Strength:_____________
Do you: Always burn☐ Always burn, then tan☐ Sometimes burn, then tan☐ Never Burn ☐

Section V: Review of Systems

General	Yes	No	Cardiovascular system	Yes	No
Tire easily	☐	☐	Chest pain or discomfort	☐	☐
Persistent Fever	☐	☐	Difficulty breathing while lying down	☐	☐
Sensitivity to cold or hot	☐	☐	Bluish fingers or lips	☐	☐
Irritability	☐	☐	High Blood pressure	☐	☐
Sleeplessness	☐	☐	Vein Trouble	☐	☐
Marked weight loss	☐	☐	Palpitations	☐	☐
Marked weight gain	☐	☐			

Skin	Yes	No	Digestive System	Yes	No
Rash	☐	☐	Difficulty swallowing/choking	☐	☐
Change in moles	☐	☐	Heartburn	☐	☐
New Moles	☐	☐	Bloating	☐	☐
Change in hair	☐	☐	Belching/excessive Gas	☐	☐
Change in nails	☐	☐	Nausea/vomiting	☐	☐
Itching	☐	☐	Rectal Bleeding/Tarry Stools	☐	☐
Acne	☐	☐	Constipation	☐	☐
Scarring	☐	☐	Diarrhea	☐	☐
Sensitivity to Products	☐	☐	Change in Appetite	☐	☐

Eyes	Yes	No	Ears	Yes	No
Trouble Seeing	☐	☐	Loss of hearing	☐	☐
Eye Pain	☐	☐	Ringing in ears	☐	☐
Red/irritated eyes	☐	☐	Drainage	☐	☐
Blurred Vision	☐	☐	Dizziness	☐	☐

Nose	Yes	No	Mouth/Throat	Yes	No
Loss of smell	☐	☐	Sore Gums	☐	☐
Frequent colds	☐	☐	Loose/broken teeth	☐	☐
Congestion	☐	☐	Bleeding Gums	☐	☐
Nose Bleeds	☐	☐	Hoarseness	☐	☐
Drainage	☐	☐	Sore throat/difficulty swallowing	☐	☐

Respiratory	Yes	No	Endocrine	Yes	No
Cough	☐	☐	Thyroid Issues	☐	☐
Sputum	☐	☐	Weight gain	☐	☐
Shortness of breath	☐	☐	Weight loss	☐	☐
Wheezing	☐	☐	Change in menstrual cycle	☐	☐
Pain with breathing	☐	☐	Fatigue	☐	☐

Genito-urinary	Yes	No	Nervous System	Yes	No
Pain with urination	☐	☐	Headaches	☐	☐
Blood in Urine	☐	☐	Fainting	☐	☐
Painful sex	☐	☐	Memory Loss	☐	☐
Discharge	☐	☐	Numbness/Tingling	☐	☐
Erectile dysfunction	☐	☐	Weakness in limbs	☐	☐
Itching/burning	☐	☐	Poor coordination/falling	☐	☐
Rashes/lesions	☐	☐	Seizure	☐	☐

Musculoskeletal	Yes	No	Breast	Yes	No
Muscle cramps	☐	☐	Lumps	☐	☐
Pain/swelling joints	☐	☐	Discharge	☐	☐
Stiffness	☐	☐	Change in nipple or skin	☐	☐
Back/neck pain	☐	☐	Tenderness	☐	☐

I have reviewed and answered all questions to the best of my knowledge.

Signature:____ Date__________________________

Massage Patients Only

Do you have any of the following:

- ☐ **recent injury**
- ☐ **disc problems**
- ☐ **broken bones**
- ☐ **mid back pain**
- ☐ **low back pain**
- ☐ **neck pain**
- ☐ **Allergies to scented oils**

✶I understand that massage is not a replacement for medical care and that no diagnosis will be made.
✶I am responsible for paying for my appointment at the time of service or for cancellations made less than 12 hours before my scheduled appointment.
✶I understand "No Shows" will be charged for the massage appointment prior to scheduling another massage.
✶If I am late my appointment time may be reduced

Signature____ Date______________________________________

Aesthetic/Laser Patients

Do you have skin allergies,hypersensitivity, or get cold sores? Yes☐ No☐
Please explain: ____

List your current skincare program/products:

Circle the treatments you have had before and list the last date of treatment and any reaction you may have had.
Chemical peel
Botox
Dermal Fillers
Laser
Hair Removal
Microdermabrasion
Microneedling
PRP
Facial surgery: Type____

Skin Type:Dry☐ Oily☐ Combination☐ Red☐ Acne☐

Do you have any tattoos? Yes☐ No☐ Permanent Cosmetics? Yes☐ No☐

I have answered these questions truthfully and will notify you of any changes in medications or conditions.
Signature: Date: