PAGE 1, FEMALE BIH HEALTH HISTORY

ALLURA skin, laser & wellness clinic

PLEASE TAKE A MOMENT TO COMPLETE OUR FEMALE MEDICAL HEALTH HISTORY FORM

Today's Date: _____

Last Name: _____ **First Name:** _____ **MI:** _____

Nick Name: _____ **Sex (please circle one):** Female Male Transgender

Date of Birth: _____ **Age:** _____

Street Address: _____ **P.O. Box Number (if applicable):** _____

City: _____ **State:** _____ **Zip Code:** _____

Phone Numbers: **Home:** _____ **Cell:** _____ **Work:** _____

Preferred phone number for contact: □ Home □ Cell □ Work

Email Address (Please print legibly):

_____

YOUR EMAIL ADDRESS IS OUR HORMONE DEPARTMENT'S PREFERRED MEANS OF CONTACTING YOU

May we send you text appointment reminders? □ YES □ NO
May we send you an email for appointment reminders/medical/additional scheduling information? □ YES □ NO
…for our monthly specials/special event information? □ YES □ NO □ I do not wish to receive these notifications
May we send you regular mail? □ YES □ NO
May we leave you a voicemail? □ YES □ NO
May we leave a message with someone else? □ YES □ NO

Occupation: _____

Marital Status: □ Married □ Divorced □ Single/Never Married □ Widowed □ Living with Significant Other

Ethnicity: □ Caucasian (Not Hispanic or Asian) □ Hispanic □ Asian □ Black/African-American □ Other _____

Language: □ English □ Spanish □ Other _____

Emergency Contact Information:

Name: _____ Relationship: _____ Phone: _____

Who may we release *medical* or *appointment information* to?

Name: _____ Relationship: _____ Phone: _____

Preferred Pharmacy: _____

Location: _____ Phone: _____

Preferred Lab: _____ Location: _____

Physician Name: _____ Phone: _____

How did you hear of Allura / who may we thank for referring you? (Please check all that apply):

□ Internet □ Magazine □ Newspaper □ Billboard □ Mailer □ Staff Member □ Physician □ Other

□ Allura client / Family Member / Friend: _____

□ Physician: _____

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We are honored that you have chosen Allura Skin, Laser, and Wellness Center.
Please state the reasons for your visit: _____

MEDICAL HISTORY:

Please mark if you or a family member has or has ever had any of the following conditions:

You		Condition	Family	
Y	N	Diabetes	Y	N
Y	N	Hypertension	Y	N
Y	N	Heart Disease	Y	N
Y	N	High Cholesterol	Y	N
Y	N	Heart Murmur	Y	N
Y	N	Rheumatic Fever	Y	N
Y	N	Atrial Fibrillation	Y	N
Y	N	Stroke	Y	N
Y	N	Bleeding Disorders	Y	N
Y	N	Blood Clots	Y	N
Y	N	Polycythemia/Hemochromatosis	Y	N
Y	N	Varicose Veins	Y	N
Y	N	Leukemia/Lymphoma/MM	Y	N
Y	N	Liver Disease	Y	N
Y	N	Hepatitis A__ B__ C___	Y	N
Y	N	HIV	Y	N
Y	N	Hypothyroid/Hashimoto's	Y	N
Y	N	Hyperthyroid/Graves' Disease	Y	N
Y	N	Other thyroid problems	Y	N
Y	N	Asthma/Emphysema/COPD	Y	N
Y	N	Chronic Bronchitis	Y	N
Y	N	Kidney Disease	Y	N
Y	N	Crohn's/Celiac Disease	Y	N
Y	N	Lactose/Gluten Intolerance	Y	N
Y	N	Irritable Bowel	Y	N
Y	N	Colon Polyps	Y	N
Y	N	Breast Cancer	Y	N
Y	N	Colon Cancer	Y	N
Y	N	Lung Cancer	Y	N
Y	N	Ovarian Cancer	Y	N
Y	N	Prostate Cancer	Y	N
Y	N	Rectal Cancer	Y	N
Y	N	Anxiety	Y	N
Y	N	Depression	Y	N
Y	N	Psychiatric Disorder: Bi Polar	Y	N
Y	N	Auto Immune Disorders: Lupus	Y	N
Y	N	Rheumatoid Arthritis	Y	N
Y	N	Scleroderma	Y	N
Y	N	Osteopenia/Osteoporosis	Y	N
Y	N	Arthritis	Y	N
Y	N	Chronic Pain/Fibromyalgia	Y	N
Y	N	Alzheimer's Dementia	Y	N
Y	N	Multiple Sclerosis	Y	N
Y	N	Parkinson's	Y	N

Weight: _____ **Height:** _____

Drug Allergies and Reactions:

_____
_____

Previous Surgeries or Procedures:

_____
_____
_____
_____
_____

Hospitalizations or Treatments:

_____
_____
_____
_____

Current Medications and Doses:

_____
_____
_____
_____
_____
_____
_____

Vitamins, Supplements and Herbs:

_____
_____

Do you take Aspirin or other anti-inflammatories on a daily basis? □ YES □ NO

Social History:

Do you smoke? □ YES □ NO
If yes, number per day ____ How many years? ____
Recreational drug use? □ YES □ NO
Do you drink Alcohol? □ YES □ NO
If yes, number of drinks per week? ____
How many days per week do you exercise? ____

_____
Patient Signature **Date**

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ALLURA skin, laser & wellness clinic

TODAY'S DATE: _____

SYMPTOM	Frequent	Rare	Never	SYMPTOM	Frequent	Rare	Never
Anxiety				Memory Loss			
Decrease in energy/fatigue				Muscle and/or Joint pain			
Decrease in sex drive				Mood Swings			
Depression				Night Sweats			
Difficulty concentrating				Pain with Intercourse			
Fogginess in thinking				Sleep Disturbance			
Headaches/Migraines				Urine Leakage			
Hot Flashes/flushes				Vaginal Dryness			

Which sexual orientation best describes you?
Heterosexual __ Homosexual __ Bisexual __

Number of Pregnancies: ___
Number of Live Births: ___ Miscarriages: ___
Number of Vaginal births: ___ C/Sections: ___

Are you currently sexually active? □ YES □ NO
If yes, what type of birth control do you use?
_____
If no, have you ever been sexually active? □ YES □ NO

Have you ever been treated for any of these infections?
Please check all that apply:
Bacterial Vaginitis __ Chlamydia __ Condyloma __
Gardnerella __ Gonorrhea __ Herpes __
HIV __ PID __ Syphilis __
Yeast __ Warts __ Other _____

Date of last Pap Smear: _____
Was it normal? □ YES □ NO
If NO, how was it treated? _____

Have you ever had any of the following cancers?
Breast □ YES □ NO Date & Treatment:_____
Cervical □ YES □ NO Date & Treatment:_____
Ovarian □ YES □ NO Date & Treatment:_____
Uterine □ YES □ NO Date & Treatment:_____

Have you ever been tested for the BRCA gene?
□ YES □ NO Results: _____

Have you ever had a Mammogram? □ YES □ NO
Date of Last Mammogram: _____
Was it normal? □ YES □ NO
If NO, describe treatment: _____
Do you perform self-breast exams? □ YES □ NO
If YES, number of times per month: _____

Have you ever had a Bone Density test? □ YES □ NO
If YES, the results were:
Normal ___ Osteopenia ___ Osteoporosis ____

If you are still having periods, are they regular? □ YES □ NO
If you no longer have periods, please check the reason:
Natural ___ Hysterectomy ___ Ablation ___ Medications ___
When was your LAST menstrual period? _____

Have you ever been on Hormone Replacement Therapy?
□ YES □ NO
If YES, when and what kind of therapy did you receive?
_____

Have you ever been told that you have any of the following?
Check all that apply:
Endometriosis ___ Fibrocystic Breasts ___
Fibroid Uterus ___ Ovarian Cysts ___
PCOS ___ Uterine Polyps ___
Describe treatments for any of the above: _____
_____

Do you currently have any of these symptoms?
Check all that apply:
Acne ___ Facial Hair ___ Hair Loss ____
Fluid Retention ___ Melasma ___ Rosacea ____
Weight Loss ___ Weight Gain ___

Do you have any other concerns that you would to discuss with your provider?
_____
_____
_____

_____
Patient Signature Date

_____
Provider Signature Date

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TODAY'S DATE: _____

AUTHORIZATIONS (Please initial):

_____ I consent to the taking of photographs for the purpose of documentation and future comparison.

_____ I authorize the release of information to/from my Primary Care Physician or Specialist if deemed necessary for the treatment.

_____ **I understand that my insurance company will not cover any of the procedures performed.**

_____ **Payments for all procedures or services are to be paid at the conclusion of each visit**.

_____ I understand that procedure packages are non-transferable.

I authorize that the above information is up to date and correct to the best of my knowledge.

Client Signature (Parent/Guardian if client is a minor): _____ Date: _____

Provider Signature: _____ Date: _____

Thank you for completing this paperwork!