IN ORDER TO BETTER SERVE YOU, PLEASE COMPLETE THIS 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 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: ____

2032 Lowe Street, Suite 103, Fort Collins, CO 80525 | 1615 Foxtrail Drive, Suite 190, Loveland, CO 80538
Phone: 970.223.0193 | **Fax:** 970.669.5348 | **Website:** www.AlluraClinic.com | **Email:** info@alluraclinic.com

ALLURA skin, laser & wellness clinic

PAGE 2, HEALTH HISTORY FORM

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**

PAGE 3, HEALTH HISTORY FORM

INJECTABLE/LASER/SPA Health History Form

Name: ______________________ **DOB:** ______________ **Today's Date:**______________

SKIN CARE HISTORY:

What types of **skin care products or product line(s)** are you currently using?

____

Are you sensitive to **skin care products**? □ NO □ YES

If yes, is sensitivity due to: □ Fragrances □ Irritation □ Rash □ Dryness

In your opinion, what **type of skin** do you have?

□ Dry □ Normal to Dry □ Normal □ Normal to Oily □ Oily □ Problem/blemished

How easy is it to tan your skin?

□ Always burn □ Burn at first, but can get a light tan □ Rarely burn, always tan □ Never burn, easily tan □ Always tan

Have you been treated for **acne with any of the following:** □ Oral Medications □ Creams □ Accutane

PROCEDURE HISTORY:

Have you ever had any of the following **procedures** (please check all that apply)? Please include approximate year(s).

- □ Botox/Dysport/Xeomin: ______________________
- □ Fillers: ______________________
- □ Chemical Peel: ______________________
- □ Facials: ______________________
- □ Microdermabrasion: ______________________
- □ Fractional Lasers (Fraxel, CO2, Sublative or Other): ______________________
- □ IPL (Intense Pulse Light) / FotoFacial: ______________________
- □ Body Contouring (CoolSculpting, Thermage, VaserShape or Other): ______________________
- □ Skin Tightening of Face or Eyes (Thermage or Other): ______________________
- □ Laser Hair Removal: ______________________
- □ Other Hair Removal (Electrolysis, Waxing or Dermablading): ______________________
- □ Permanent Make-Up: ______________________
- □ Teeth Whitening: ______________________
- □ Vein Treatment: ______________________

Have you had any **adverse reactions** to any of the treatments listed above? □ NO □ YES

If yes, please explain the reactions: ______________________

AUTHORIZATIONS (Please initial):

___________ I consent to the taking of photographs for the purpose of documentation and future comparison. (We will NOT use your photos for advertising or marketing purposes, unless you give us authorization below.)
These photographs **MAY** ___________ or **MAY NOT** ___________ be used for advertising purposes.
(PLEASE INITIAL ONE)

___________ 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!

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