Health Summary

Patient Name : _____ Date of Birth: _____

Todays Date: _____

Allergies

Current Medications

(include prescriptions or any over the counter vitamins, herbs, supplements, etc)

Present Health Conditions

Yes	No	Disease	Yes	No	Disease
		Anemia			Heart Attack
		Anxiety			High Blood Pressure
		Arthritis			High Cholesterol
		Asthma			Irregular Heart beat
		Blood Clot in Leg			Kidney Disease, Type:
		Blood Clot in Lung			Kidney Stones
		Blood Transfusion			Liver Disease, Type:
		Bleeding Problems, Type:			Rheumatic Fever
		Congestive Heart Failure			Skin Disease, Type:
		Depression			Stroke
		Diabetes/High Blood Sugar			Thyroid Problems, Type:
		Emphysema/Chronic Bronchitis			Tuberculosis
		Epilepsy/Seizures			Ulcers in Stomach/Bowels
		Gallstones			Other:
		Glaucoma			
		Gout			

The above information is current and correct to the best of my knowledge. I have reviewed the above history.

_____ _____

_____ _____

Patient Signature Date Aesthetic Nurse Date