General Information and Medical History

Date _____

Name _____ **DOB**_____

Gender(circle one) Male Female

SSN ___-___-___ and/or Driver's Lic. # _____ exp_____

Address_____ **City/State/Zip**_____

Marital Status(circle one): single married divorced widowed

Contact Phone Numbers: Best:_____ Alternate:_____

Email: _____

Preferred method of contact: (circle all that apply) email phone call text

Emergency Contact Info:

Name _____ Relationship _____

Contact Numbers: Best _____ Alternate: _____

Height:_____ Weight:_____

Please list all current prescription medication(s) prescribed by a health care professional:

Drug	Dosing	#/day	Which Dr.	Why

Please list all current OTC (OVER-THE-COUNTER) medication. (Include vitamins, supplements, herbs, etc)

Med Name	Dosing	#/day	medically suggested/self-taken

Do you have any drug or food allergies? (Circle one) YES NO UNSURE

If yes, which drug(s) and/or food(s): _____

Primary Care Physician: _____

Please list any medical problems you are currently seeing a medical professional for, and the age you were first diagnosed with the condition (use the back of this sheet if necessary).

Please list any surgeries and the year(s) they were performed:

Current/Past Medical History

Please circle all illnesses you have been treated for (items not circled are understood to be negative).

Abnormal bleeding	Pneumonia	Cancer	Peripheral vascular disease
Heart disease	Ulcer	Hepatitis	Kidney disease
Epilepsy/seizure	Anemia	Gout	High blood pressure
Thyroid disorder	Phlebitis	Stroke	Glaucoma
Rheumatic fever	Tuberculosis	Blood clot	Osteoporosis
Emphysema	Anxiety	Polio	Arthritis
Liver disease	Asthma	Prostate	Sexual dysfunction
Urinary problems	Depression	Diabetes	other:_____

Family History

This is important in determining your overall medical history. Please include age of onset and death where possible.

Mother

Father

Siblings

Children

Social History

Do you use tobacco of any kind? (circle one) YES NO How often?_____

Do you drink alcohol? YES NO How often?_____

Do you have a good support system for a wellness program?_____

What diets have you tried? List all that apply and any results: _____

_____

BLOOD WORK-EARLY DETECTION

If you have had the following tests, please indicate approximate date of testing and the result (what did your MD prescribe)

___cholesterol/lipid blood test _____
___exercise stress test _____
___EKG _____
___Chest X-Ray _____
___colonoscopy _____
___other _____

STRESS ANALYSIS

Rate your stress from 1(low) to 10(high): 1 2 3 4 5 6 7 8 9 10

What are your sources of stress? _____

_____

How do you cope (or relieve yourself from stress and frustration)? _____

_____

GOALS

Please share with us your health goals, why you are here for this consultation, and your desired results from this program. Please INCLUDE your goal weight and most common foods you enjoy. Also include any other information you feel may help us in determining the best course of action for your body's ideal well-being.

_____
_____
_____
_____

What are you interested in? (Please select all that apply)

___Medical Weight Loss
___Botox and/or facial fillers
___Body Reshaping (Exills)
___Chemical Peel
___Hormone Therapy
___Latisse(eyelashes)
___Nutritional counseling
___Microdermabrasion

HOW did you hear about us?

___TV ___Radio ___Magazine
___Facebook ___Twitter ___Linkedin
___Google Search
___I know an employee_____
___I know a patient_____

Bluegrass
MEDICAL AESTHETICS

The patient certifies that all information provided to this office is true and correct, to the best of their knowledge. The patient grants their consent to this office and its staff to render treatment as deemed necessary by the attending physician. If the patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am the legal guardian of the child, and grant my consent for the treatment of the child as provided for herein. The patient my refuse treatment at any time. ____INITIAL

Patient understands that they are responsible for payment to Bluegrass Medical Aesthetics and that they are responsible for any and all collection costs in addition to their bill that may arise, including collections fees, court costs and reasonable attorney fees should action be taken. Accounts 90 days past due are subject to interest of 1 ½% per month on the unpaid balance. Patient hereby releases and forever discharges the aforesaid treatment from any and all responsibility or liability of any kind, nature or character whatsoever arising from said treatment. ____ INITIAL

By initialing and signing this form, the patient gives their permission to be contacted via Telephone, Text message and/or Email for Appointment Reminders, Promotions and Well-Wishes. We will keep this information private for the sole use of Bluegrass Medical Aesthetics, LLC. _____ INITIAL

Patient's Signature:_____Date:_____

Guardian's Signature Authorizing Care: _____Date:_____