360 MedSpas

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Contact Information

Date:	Name:	Home Phone:
Street Address:		
City:		State & Zip:
DOB:	Age:	Cell:
Email:		Work:
Emergency Contact:		
	Home:	Cell:
Referred By:		

Health Histiory

List Medications Here (prescription and over-the-counter vitamins, herbal medications):

List Allergies Here:

SURGERIES:

List Surgery	Date

Do you have a history of any of the following? Place an "x" by all that apply.

☐	Heart Disease	☐	Mental Disease	☐	Neuro-Muscular Disease
☐	Diabetes	☐	Excessive Bleeding	☐	Auto-Immunine Disorder
☐	Liver Disease	☐	High Blood Pressure	☐	Cold Sores/Fever Blisters

Are you?	☐	Pregnant	☐	Nursing
Do you?	☐	Smoke	☐	Drink Alcohol, Amount/Day_____

The information I've provided above is true and accurate to the best of my knowledge.

Signature: **Date:**