

Thrive Wellness & Aesthetics

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BRIEF MEDICAL HISTORY

Name _____

Phone _____ Age _____ Ht _____ Wt _____

Address _____

City/State _____ Zip _____

MEDICATIONS:

ALLERGIES:

Are you pregnant or lactating? _____

Physician's Name _____

Circle any of the following illnesses you have or have ever had in the past (or family history):

Myasthenia Gravis Hepatitis Eye Disease Autoimmune Disease Numbness

Vision Problems Muscle Weakness Amyotrophic Lateral Sclerosis (ALS)

Eaton Lambert Disorder

I am not on Aminoglycosides or any other antibacterial medication to treat bacterial infections.

Explain: _____

Previous Hospitalization/Operations:

I understand the information on this form is essential to determine my medical and cosmetic needs and the provision of treatment. I understand that if any changes occur in my medical history/health, I will report it to the office as soon as possible. I have read and understand the above medical questionnaire. I acknowledge that all answers have been recorded truthfully and will not hold any staff member responsible for any errors or omissions that I have made in the completion of this form.

Client Signature:

_____ Date: _____