Vedas Medical Spa & Wellness Center
2626 Research Forest Dr
The Woodlands, TX 77381
281-298-5476 www.vedasmedspa.com

Medical History Form

Name _____ Referred by: _____

Birthdate (mm/dd/yy): _____ City: _____

Address _____ Zip Code _____

Work Phone: _____ Best Contact Number: _____

Can leave a message at: Home ☐ Work ☐ Cell ☐ Email ☐

Email Address: _____

Emergency Contact Name and Number: _____

Age _____ Height _____ Weight _____

There exists a risk if our staff is not aware of the general health and medical background of a client. This information may critically affect what procedure we may recommend or safely undertake. Please provide us with the following information and keep it updated.

Please circle all of the following medical conditions you now have or have had in the past, <u>if you have had none, please circle "None of the above"</u>

bleeding tendency / diabetes / blood transfusions / glaucoma / dry eyes / lung disease / TB / asthma or wheezing / emphysema / bronchitis / irregular heart beat / chest pain / heart disease / high blood pressure / pace maker / heart attack / stroke / epilepsy / heart burn / intestinal ulcers or bleeding / rheumatoid arthritis / scleroderma / lupus / porphyria / depression / mental illness / drug or alcohol addiction / hepatitis B / hepatitis C / HIV / contact lenses / loose or chipped teeth / dentures / dental implants / veneers / caps / **None of the above** / **any other serious illness or injury please explain**:

_____

Please list all medications that you are currently taking or have used in the past 6 months. **Use the back of page if necessary.**

Medication(s)	Amount	Frequency

Please list all Naturopathic, Health Food Supplements and Vitamins:

Please list all **ALLERGIES** including **LATEX**: _____

Are you a smoker? Yes ☐ No ☐ If you are an ex-smoker, for how long are you smoke free? _____

How much are (were) you smoking? _____ For how long? _____

How much alcohol do you drink per week? _____ Caffeine per week? _____

Is there any possibility that you may be pregnant at this time? Yes ☐ No ☐

Do you have a history of cold sores? Yes ☐ No ☐ If yes, when was your last outbreak? _____

Do you or your family have a history of atypical moles, vitiligo, developing keloids, melanoma or skin cancer? Yes ☐ No ☐

If yes, please circle which and explain: _____

Please list all surgeries that you have had (include plastic surgery and wisdom teeth removal) with the date you had the surgery:

_____

_____

_____

Have you or anyone in your family ever had or have a history of unusual reactions or problems with **LOCAL** anesthesia (dental freezing), **TOPICAL** anesthesia (anesthetic creams or gels) or **GENERAL** anesthesia (rashes, muscle weakness, jaundice, breathing problems or unexpected fevers(s))? Yes ☐ No ☐

If yes, please explain: _____

Physician Name: _____

I acknowledge that I have disclosed my complete medical history and the above is a complete and accurate representation of my medical and psychological status. I, _____, represent to the physicians and staff that I am at least 18 (eighteen) years of age or, if not, am accompanied by a legal guardian. I hereby consent to and authorize a history examination by my doctor and such assistant or staff as may be assigned by him/her.

If appropriate, I authorize the release of any medical information for the purpose of processing insurance claims on my behalf. I authorize payments of medical benefits directly to the doctor for services provided to me. A copy of this authorization shall be considered as valid as the original. I understand that photography is a necessary part of planning and evaluating cosmetic procedures. I authorize the taking of photographs at the direction of my physician or physician delegate and under such conditions as may be approved by him/her. These photographs will be used solely for documentation purposes and will be kept confidential unless otherwise disclosed.

SIGNATURE: _____ DATE: _____

RELATIONSHIP: (circle one) PATIENT SPOUSE PARENT GUARDIAN