Medical History Review

NAME: _____ TODAYS DATE: _____ DOB: _____

ADDRESS: _____ CITY/STATE/ZIP:_____

PHONE NUMBER: _____ EMAIL ADDRESS_____

HEIGHT: _____ CURRENT WEIGHT: _____ BLOOD PRESSURE: _____ BMI: _____

PHARMACY PREFERRED_____ PHARMACY #_____

MEDICAL CONDITIONS/ILLNESSES:

_____

_____

MEDICATIONS AND WHAT IT IS PRESCRIBED FOR:

_____

_____

ALLERGIES:

_____

Circle any of the following illnesses you have or have ever had in the past:

- ☐ Myasthenia Gravis
- ☐ Herpes/Shingles
- ☐ Facial Surgery
- ☐ Cancer
- ☐ Facial Fillers
- ☐ Eye Disease
- ☐ Easy bleeding
- ☐ Vision Problems
- ☐ Multiple Sclerosis
- ☐ Keloid Formation
- ☐ Take antibiotics for Dental Procedures
- ☐ Hepatitis
- ☐ History of MRSA
- ☐ Persistent Muscle Weakness
- ☐ Heart Rhythm Disorder
- ☐ Hx of Chemotherapy or Radiation Therapy

Are you pregnant or nursing? _____ Is so, physicians name: _____

Have you been in the hospital or had an operation in the last 2 years? Yes: _____ No: _____

If yes, please explain: _____

I have read and understand the above medical questionnaire. I understand the information on this form is essential to determine the medical 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 acknowledge that all the 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. I understand that my office visit/s are required and are NON refundable. I have received a copy explaining all of the risks associated with the medications/vitamin injections. I will comply with the instructions of this medication given to me by Total Wellness Center.

Our clinic strives to make payment options convenient for our patients, accepting most major credit and debit cards, cash, and checks. Please note, if a check is returned due to non-sufficient funds (NSF), additional fees will apply, and we kindly request the balance be paid within 24 hours; otherwise, a $50 daily late fee will be charged until the payment is made in full. After three days of non-payment, the account will be turned over to our legal team, and you will also incur all legal fees associated. For in person credit or debit card payments, a 3% processing fee will be applied. If the card is not present or payment is made over the phone, a 4% processing fee will be applied.

Patient Signature: _____ Date: _____

Visit #_____