Blue Srpuce Cosmetic & Spa Clinic

16729-100 St
Edmonton, AB
T5X 3Z9
Tel: 780-457-1351
Fax: 780-478-7796

Medical History Form

Last Name:	First Name:	Best Phone:
Address:		
City:	State:	Zip Code:
Family Doctor:		Phone:
Emergency Contact:		Phone:

D.O.B.:	Age:	Height:	Weight:	If previous weight loss greater than 25lbs., how long ago?

Sex: ☐ Male ☐ Female Race: ☐ White ☐ Black ☐ Hispanic ☐ Asian ☐ Other

1. Are you currently under a doctor's care, if so, for what reason?

2. Do you take or use **ANY** medications, herbal or natural supplements or topicals on a regular basis? **Please List All:**
3.

3. (For women) Are you, or could you be pregnant? ☐ Yes ☐ No

4. Do you have a history of Keloid scarring? ☐ Yes ☐ No

5. Do you have a history of Fever Blisters, Cold Sores or Herpes? ☐ Yes ☐ No Location?

6. Do you have **ANY** allergies to medications, cosmetic ingredients, foods, latex or others substances? **Please List All:**
7.

7. Do you have any permanent makeup implants or tattoos? ☐ Yes ☐ No If yes, please list type and location:

8. Have you ever been hospitalized or had any surgeries including cosmetic procedures? ☐ Yes ☐ No If yes, describe below:

Year Diagnosis	Reason for Hospitalization	Description/Outcome

9. Have you ever had any other cosmetic procedures not listed above? ☐ Yes ☐ No If yes, describe below:

10. Please use the space below to describe any **ALL PRESENT OR PAST** medical problems including High Blood Pressure, Diabetes, Arthritis, Thyroid Problems, Cancer, Heart Disease, Milk Allergy, Lung Disease, Ulcers, Blood Vessel Disease, High Blood Cholesterol, Kidney Disease, Gallstones, Liver Disease, Back problems, Intestine (Bowel) Problems, Seizures or any others.

Year Diagnosis	Problem	Description

Signature: _____ Date: _____