# BRIEF MEDICAL HISTORY AND INFORMED CONSENT

Name___________________________Phone_______________Age_____Ht______Wt_____

Address___________________________City/State__________________________ Zip________

MEDICATIONS:___________________________________________________________________

ALLERGIES:____________________________________________________

Women: Are you Pregnant?___________________

Physician's
Name:______________________________________________________________________

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

Myesthenia Gravis Hepatitis Eye Disease Autoimmune Disease Vision Problems Numbness Muscle Weakness Amyotrophic Lateral Sclerosis (ALS)

Explain:_____________________________________________________________

_________________________________________________________________________

Previous Hospitalizations/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 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.

Signature_____________________________________________Date_____________________