History and Intake Form

Medications: (Please enter all current medications)

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Allergies: (Please enter all allergies)

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Is it possible you are pregnant?_____________
Are you breast feeding? _____________

Past Medical History: (please circle all that apply)

Anxiety	**Depression**	**Leukemia**
Arthritis	**Diabetes**	**Lung Cancer**
Asthma	**End Stage Renal Disease**	**Lymphoma**
Atrial fibrillation	**GERD**	**Prostate Cancer**
Bone Marrow	**Hearing Loss**	**Radiation Treatment**
Transplantation	**Hepatitis**	**Seizures**
Breast Cancer	**High Blood pressure**	**Skin Cancer**
Colon Cancer	**HIV/AIDS**	**Stroke**
COPD	**High Cholesterol**	
Coronary Artery Disease	**Thyroid Problems**	**NONE**

If you have had any of the above, please describe in detail:
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Interest In: (please circle all that apply)

Hair Transplantation	
Hair loss	**Botox**
PRP	**Fillers**
Wrinkles	**Scar/ Acne Scarring**
Double Chin	**Chemical Peel**
Broken Blood Vessels	**Aging Face Evaluation**
Tattoo Removal	**Freckle/ Age Spot Removal**

Other ____