

Patient Personal Health History

Fillable form • Complete prior to your visit • Not for emergencies

Skin & Sculpt Medical Spa • Knoxville, TN

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This form collects personal health information. Please complete and bring it to your appointment, or submit via a secure method provided by our office. Avoid emailing completed forms unless using an encrypted, HIPAA-compliant email service.

Patient Information

Name* (First) Last* Email*

Phone* Occupation

Address* (Street Address)

Address Line 2

City* State/Region* ZIP* Country

Marital Status Sex

Date of Birth (mm/dd/yyyy) Age Referred by

Personal Physician Date of Last Physical Exam

Medications & Allergies

Medications (Name / Frequency) — include prescription, OTC, herbs, vitamins

Allergies — list and describe reaction (e.g., latex, foods, medications, environmental)

Bring this completed form to your appointment or submit via an approved secure method.

Questions: (865) 671-3630

info@skinandsulptmedspa.com

Patient Personal Health History

Medical History • Check all that apply

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Medical History (Check all that apply)

- | | |
|------------------------------|--------------------------------|
| Acne | Thyroid disorder |
| Alcohol/substance abuse | Intestinal Disorders |
| Allergies | Ulcers |
| ADD/ADHD | HIV/AIDS |
| Anxiety or depression | Polycystic Ovary |
| Anemia | Herpes Simplex |
| Asthma | Pregnancy |
| Bleeding/clotting disorder | Psychological Disorders |
| Crohns/Ulcerative Colitis | Bipolar Disorders |
| Kidney stones | Obsessive Compulsive Disorder |
| Rheumatoid Arthritis | Cardiac Arrhythmia |
| Seizures | High Cholesterol |
| Systemic Lupus Erythematosus | Chronic Fatigue Syndrome |
| Diabetes | +TB test |
| Eating disorders | Cancer or Tumor |
| Eczema or psoriasis | Multiple Sclerosis |
| Headaches/Migraines | Myasthenia Gravis |
| Heart disease | Smoker (Present/Past) |
| High Blood Pressure | Sexually Transmitted Infection |

Surgical, Hospitalizations, Trauma History

Please list the type and date of any surgeries, hospitalizations, or serious injuries.

Patient Personal Health History

Family history • Attestation

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Family History (Check all that apply)

Heart Disease

Hypertension

Alcohol/Drug Abuse

Stroke

Diabetes

Mental Illness

Cancer

High Cholesterol

Eating Disorder

Attestation & Signature

To the best of my knowledge, the above information is true. I have not knowingly withheld any information about my past or present health condition.

I agree to the attestation above.

Signature (Type Full Name)*

Date

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Questions? Call (865) 671-3630.