L.I.V. Medical Weight Loss & Aesthetics

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livmedicalweightlossaesthetics.com

BRIEF MEDICAL HISTORY

Name ____

Phone __________________________ Age __________ Ht ________ Wt_______

Address____

City/State_________________________________ Zip________________________

MEDICATIONS:

____

____

ALLERGIES:

____

Women are you pregnant or lactating? ____________________________________

Physician's Name____

Circle any of the following illnesses you have or have ever had in the past (or family history):

Myasthenia Gravis Hepatitis Eye Disease Autoimmune Disease
Numbness Vision Problems Muscle Weakness
Amyotrophic Lateral Sclerosis (ALS) Eaton Lambert Disorder

I am not on Aminoglycosides or any other antibacterial medication to treat bacterial infections.

Explain: ____

____

Previous Hospitalization/Operations:

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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 medical history/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.

Client Signature:

____ Date:______________