the renewal center

Health Information Questionnaire

Name:______________________ Date:______________

Address:______________________ City& Zip:______________

Home:__________ Cell:__________ Work:__________

Email:______________________ DOB:______________

Emergency Contact:______________________________

Please check all that apply:

- _____ AIDS/HIV
- _____ Anemia
- _____ Arthritis
- _____ Auto Immune Deficiency
- _____ Asthma
- _____ Blood Disease/Bleeding Disorder
- _____ Chemotherapy
- _____ Diabetes
- _____ Dizziness
- _____ Epilepsy
- _____ Fainting
- _____ Heart Disease
- _____ Hepatitis
- _____ High Blood Pressure
- _____ Hyperpigmentation
- _____ Infection (Active)
- _____ Keloids or dark scars
- _____ Liver Disease
- _____ Lupus
- _____ Melanoma
- _____ Mental Disorder
- _____ Nervous Disorder
- _____ Phlebitis/Blood Clots
- _____ Radiation Treatment
- _____ Respiratory Problems
- _____ Skin Conditions/Cancer
- _____ Sinus Problems
- _____ Stomach Problems
- _____ Stroke
- _____ Thyroid Problems
- _____ Tuberculosis
- _____ Ulcers
- _____ Venereal Disease
- _____ **Medication Allergies:**

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Have you ever/are you using:

	Yes	No
Retin-A, Renova, any retinoic acid	_____	_____
Accutane in the last 9 mths	_____	_____
Prescription Acne Medication	_____	_____
Birth Control Pills	_____	_____
Steroids	_____	_____
Are you pregnant?	_____	_____
Due Date ______________		
Are you lactating?	_____	_____