Metro Medispa
AGE MANAGEMENT & REJUVENATION

Bio-Identical Hormone Replacement Therapy

Confidential Medical History

Name_____ Date_____ Height _____Weight_____

Address_____ Date of Birth_____ Age_____ Sex_____

_____ Telephone_____

Email _____Primary Physician_____

Allergies	Yes	No
Penicillin	__	__
Codeine	__	__
Sulfa Drug	__	__
Morphine	__	__
Aspirin	__	__
Food Allergies	__	__
Dye Allergies	__	__
Nitrate Allergies	__	__
No Known Allergies	__	__
Pet Allergies	__	__
Seasonal	__	__
Other_____		

Used	How often?
Tobacco	_____
Alcohol	_____
Caffeine	_____

Over the Counter Issues:	Yes	No
Pain Reliever	__	__
Aspirin	__	__
Acetaminophen	__	__
Ibuprofen	__	__
Naproxen	__	__
Ketoprofen	__	__
Cough Suppressant	__	__
Antihistamine products	__	__
Decongestant product	__	__
Sleep Aids	__	__
Antidiarrheals	__	__
Laxatives	__	__
Diet Aids	__	__
Antacids	__	__
Acid Blockers	__	__
Other_____		

Medical Conditions	Yes	No
Heart Disease	__	__
High Cholesterol or lipids	__	__
High blood pressure	__	__
Cancer	__	__
Ulcers	__	__
Thyroid Disease	__	__
Hormonal related issues	__	__
Blood clotting problems	__	__
Lung condition	__	__
Diabetes	__	__
Arthritis or joint issues	__	__
Depression	__	__
Epilepsy	__	__
Headaches/migraines	__	__
Eye disease	__	__
Other_____		

Current Medications/Vitamins/Supplements	Strength	Date Started	Dosage per day
1._____			
2._____			
3._____			
4._____			
5._____			