Anderson College
Patient Medical History

Date_____

Name: _____ **Wt.** _____ **Ht.** _____ **Age:** _____

Address: _____

Phone #: _____

Past Medical History: Circle any of the following that you have had.

Allergies or Asthma	Congestive Heart Failure	Hemorrhoids	Migraines
Alcoholism	Depression	Hepatitis (Jaundice)	Phlebitis
Anemia	Diabetes	High Blood Pressure	Psoriasis
Arthritis	Drug Abuse	Heart Blockage	Hernia
Breast lumps/cysts	Eczema-Hives	Kidney Stones	Stroke
Cancer (Tumors)	Epilepsy or Seizures	Liver Disease	Suicide Attempt
Cataracts	Heart Attack	Lung Disease	Thyroid Disease

Other: _____

Medications: [List all you are taking, the dosage (strength), and how often you take it.]

1. _____
2. _____
3. _____
4 _____
5 _____
6 _____

Drug Allergies: _____

Other Allergies: _____

List All OTC Medications you are taking, herbal and not herbal.

_____
_____
_____
_____

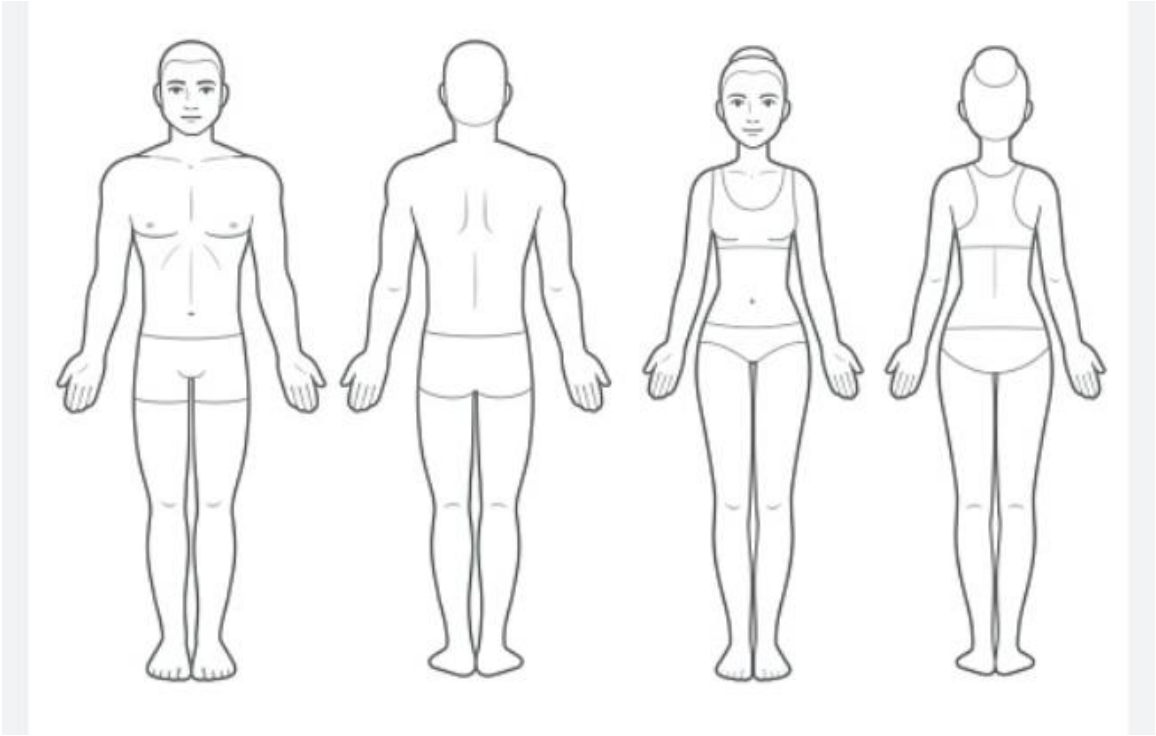
Within the Last six months:

	YES	NO
1. Have you had any problems with your heart?		
2. Have you been diagnosed with Cancer, tumors, lymphomas?		
3. Have you been diagnosed with skin cancer?		
4. Have you suffered from (Palpitations, murmur, chest pain, heart attack, etc.)		
5. Have you had any problems with blood pressure?		
6. Have you had any problems with your lungs? (Breathing problems, cough, asthma, emphysema, bronchitis)		
7. Do you have a severe cold, cough, nasal congestion or fever now?		
8. Do you have diabetes? If yes, how many years?		
9. Do you take insulin injections?		
10. Have you had hepatitis, jaundice?		
11. Have you had any kidney or bladder problems?		
12. Have you received blood transfusions? If so, when?		
13. Have you had convulsions or seizures?		
14. Have you suffered from depression/ anxiety/ sleeping disorders?		
15. Any back problems?		
16. Have you had any problems with anemia?		
17. Have you had any problems with excessive bleeding?		
18. Have you had a history of stomach ulcers/hiatal hernia/indigestion?		
19. Do you have loose teeth, dentures, caps, or crowns? (If yes, please circle)		
20. Do you smoke? If so, how many packs a day? How many years?_____		
21. Do you drink alcohol? If so, how much?		
22. Any muscle disease in your family? (Muscular Dystrophy, Multiple Sclerosis, etc.)		
23. Are you pregnant or breastfeeding?		
24. Are you trying to get pregnant?		
25. Are you under hormonal therapy?		
26. Have you had any cosmetic or Esthetic Procedures?		

Esthetician Notes:

Please Circle the Areas of your Body That You Would like to Improve.





I _____Aknowelde that I have read this information in full and have answered all questions truthfully

_____ _____

Client Signature **Esthetician Signature**