Confidential Medical Questionnaire/Personal Record

Please check 🗹 to indicate if you have or have had any of the following.

|  |  |  |  |
| --- | --- | --- | --- |
| Abnormal Heart Condition |  | Cerebral Incidents (i.e. Stroke) |  |
| Rheumatic Fever |  | Epilepsy |  |
| Hemophilia |  | Diabetes |  |
| Anemia |  | Kidney Disease |  |
| High Blood Pressure |  | HIV/AIDS |  |
| Low Blood Pressure |  | Hepatitis |  |
| Prolonged Bleeding |  | Herpes |  |
| Fainting Spells or Dizziness |  | Eczema |  |
| Palpitations |  | Keloid Scars |  |
| Healing Problems |  | Scar Easily |  |
| Bruise or Bleed Easily |  | Surgery  |  |

|  |  |
| --- | --- |
| Are you undergoing any treatment for any conditions at present? |  |
| List all the medications you have been taking in the last 6 months |  |
| Have you taken an aspirin or ibuprofen in the last 2 days? |  |
| Name of Doctor: |  |
| Address of Doctor: |  |
| Do you suffer from any allergies (including latex)? Please list all |  |
| Have you had any cosmetic procedures in the past? i.e. Hair transplant, Botox, dermal fillers |  |

In signing below, I give my consent to proceed with the SMP treatment and confirm that **I have read and agreed to the Terms and Conditions** in advance or on the treatment day and with sufficient time to understand its contents.

Client Name: ­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_