



4025 West Hopewell Road
Center Valley, PA 18034
p: 610-798-7546
f: 610-798-7543

635 North Broad Street
Lansdale, PA 19446
p: 215-362-7546
f: 215-362-7547

Young Medical Spa® Medical History Form

Last Name:		First Name:		Best Phone:	
Address:					
City:			State:		Zip Code:
Family Doctor:				Phone:	
Emergency Contact:				Phone:	
D.O.B.:	Age:	Height:	Weight:	If previous weight loss greater than 25lbs., how long ago?	
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		Race: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Other			
1. Are you currently under a doctor's care, if so, for what reason?					
2. Do you take or use ANY medications, herbal or natural supplements or topicals on a regular basis? Please List All:					
3. (For women) Are you, or could you be pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No					
4. Do you have a history of Keloid scarring? <input type="checkbox"/> Yes <input type="checkbox"/> No					
5. Do you have a history of Fever Blisters, Cold Sores or Herpes? <input type="checkbox"/> Yes <input type="checkbox"/> No Location?					
6. Do you have ANY allergies to medications, cosmetic ingredients, foods, latex or others substances? Please List All:					
7. Do you have any permanent makeup implants or tattoos? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list type and location:					
8. Have you ever been hospitalized or had any surgeries including cosmetic procedures? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe below:					
Year Diagnosis		Reason for Hospitalization		Description/Outcome	
9. Have you ever had any other cosmetic procedures not listed above? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe below:					
10. Please use the space below to describe any ALL PRESENT OR PAST medical problems including High Blood Pressure, Diabetes, Arthritis, Thyroid Problems, Cancer, Heart Disease, Milk Allergy, Lung Disease, Ulcers, Blood Vessel Disease, High Blood Cholesterol, Kidney Disease, Gallstones, Liver Disease, Back problems, Intestine (Bowel) Problems, Seizures or any others.					
Year Diagnosis		Problem		Description	

Signature: _____ Date: _____