Miami Lakes Wellness Spa
7413 Miami Lakes Drive
Miami Lakes, FL 33014
wellnessSpa.Miamilakes@gmail.com

PERSONAL INFORMATION

Name: ____________________________ Last 4# of SS#___________________________
Phone: ______________________ DOB:__________ Ht:_________ Weight:____________
Address: ____
City/State: _________________________________ Zip:_____________________________
Current Occupation: ___________________________ Employer: ___________________

CURRENT MEDICATIONS:

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____
____
____

PRESENT ALLERGIES:

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____
____

CURRENT MEDICAL CONDITIONS:

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Are you pregnant or lactating? Yes or No (circle applicable)

PRIMARY CARE PHYSICIAN:

Name: ____
Contact Number:____
Date of last visit: ____

MEDICAL HISTORY:

Indicate with (**X**) next to any illness you suffer and/or have a family history of:

Myasthenia Gravis:_____ Hepatitis:_____ Eye Disease:_____ Autoimmune Disease:_____
Chronic Numbness:_____ Vision Problems:_____ Chronic Muscle Weakness: _____
Lupus: _____ Amyotrophic Lateral Sclerosis (ALS):_____ Cancer:_____ HIV:_____
Eaton Lambert Disorder:_____ Heart Disease:_____ High Blood Pressure:_____
Diabetes:_____ Liver disease:_____ Pulmonary Disease:_____ Hemophilia:_____
Other:______ please describe: ____

PRIOR MEDICAL PROCEDURES: List the date and type of any medical procedures you have had performed during the previous ten (10) years.

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I acknowledge that the information on this form is essential to determine my medical and cosmetic needs and the provision of treatment. I understand that if any changes occur in my medical history or health I will report it to the company as soon as possible. I have read and understand the above questionnaire AND I expressly acknowledge that all the information I have provided herein is accurate and truthful. I acknowledge that the company will strictly rely on the information I have provided herein when deciding whether to engage in the procedure or services. I hereby release, indemnify and hold the company harmless from any and all liability, claims, costs and/or damages the company may suffer as a result of any inaccuracy, error and/or omission by me when completing this form.

Client Signature: _________________________________ Date: ______________

Print name: _____________________