VALOR HEALTH
WELLNESS & AESTHETICS

Patient Name: _____

Patient DOB: _____ Age: _____

Current Weight (lbs): _____ Height:_____

ALLERGIES: Please list all that apply.

_____

_____

MEDICATIONS: Please list all medications that you are taking, including prescribed and over-the-counter (such as vitamins).

_____

_____

_____

ADDITIONAL INFORMATION:

Please list anything below that you feel is important for us to know.

_____

_____

_____

FAMILY MEDICAL HISTORY:

Please list family members that have the past medical history and their relationship to you.

Family or Personal History of Kidney Disease:

_____

Family or Personal History of Thyroid Disease:

_____

Family or Personal History of Cancer:

_____

Family or Personal History of MEN I or MEN II Syndrome:

_____