



Health History

Name: _____ DOB: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone _____

Are you currently under a Physician or Nurse Practitioner's care or treatment?

Yes

No

Do you have a predisposition to herpes simplex virus?

Yes

No

Are you pregnant?

Yes

No

Do you have a history of allergic reactions or skin irritants?

Yes

No

What is your frequency of sun exposure or tanning beds?

_____ week _____ month _____ year

Please list any topical or oral medications you currently are taking:

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