Élan Med Spa

Minimum of 48 hours' notice required to cancel appointment to **avoid late fee**

Basic Information

Name: _____ Date of Birth: _____

Address: _____City:_____State:_____Zip:_____

Home Phone: _____ Mobile Phone: _____

Employer: _____ Work Phone:_____

Email Address: _____ Preferred Pharmacy: _____

Emergency Contact: _____ Phone Number: _____

How did you learn about Elan? _____

Medical History

Primary Family MD: _____

Other Specialist MDs: _____

Current Diagnoses:_____

_____

(Circle Yes, if applicable)

High Blood Pressure	Yes/No
Cardiovascular disease (heart attack, stroke, bypass surgery, angioplasty, angioplasty, stents)	Yes/No
Neurologic abnormalities (ALS, Lou Gehrig's, myasthenia gravis, Lambert-Eaton, multiple sclerosis, Bell's palsy)	Yes/No
Diabetes	Yes/No
Migraine headache	Yes/No
Eyelid lag or ptosis	Yes/No
Glaucoma or other eye problems	Yes/No
Hepatitis or HIV	Yes/No
Fever blisters	Yes/No
Keloids	Yes/No

Surgeries (list ALL): _____

_____

Allergies (list ALL): _____

HAVE YOU EVER HAD AN ANAPHYLACTIC REACTION TO ANYTHING IN THE PAST? Yes/No

Daily Medications (list ALL): _____

_____