Vitality for Life
HEALTH CENTER
560 Bryne dr. Unit 1A
Barrie, ON L4N 9P6
705.733.2033
www.vitalityforlife.ca

Health Questionnaire

Name:_____ **Age**:_____
Last Name First Name

Birthday:_____/_____/_____ **Sex:** M F
day/month/year

Occupation:_____

Address:_____

_____

_____

Email:_____

Telephone: (home)_____(work)_____

Current Skin Concerns:	How long ?

Are you currently on any **medications, vitamins/herbs?** (include name, dose and how long you have been on it)

_____ _____

_____ _____

Medical History:
Please check off any of the conditions that you may have:

__Blood coagulation disorder __Easy bruising __High blood pressure
__Pacemaker __Diabetes __Migraine
__Pregnant __Hypoglycemia __Previous plastic surgery