



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:

- | | | |
|---|--|---|
| <input type="checkbox"/> Blood coagulation disorder | <input type="checkbox"/> Easy bruising | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Migraine |
| <input type="checkbox"/> Pregnant | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Previous plastic surgery |