M.A.R.C.
MEDICAL AESTHETICS & REJUVENATION CENTER

General Health Questionnaire

Patient Name:	**Date of Visit:**
Date of Birth:	**Phone Number:**
Preferred Email:	**Emergency Contact (Name and Number):**
Address:	**Allergies**:

Medical History	
Please include all medical problems even if not relevant to this appointment. If no medical problems, write none.	
Current or Past Medical Problems	**Dates**
Hospitalizations/Surgeries	**Dates**
Medications/Supplements	**Reasons**