



Real people. Real results. Guaranteed.

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HEALTH HISTORY QUESTIONNAIRE

Name <i>(Last, First, M.I.):</i>	<input type="checkbox"/> M <input type="checkbox"/> F	DOB:
Home Address :	Phone:	
Email:		
Location of Services:		

CHECK ANY CONDITION YOU CURRENTLY HAVE

Pregnant Now, or Trying	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Active Cancer Within A Year	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Kidney Problems	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Liver Problems	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Doctor said you should avoid light?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Autoimmune disease	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Lupus Erythematosus	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Albinism	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

CHECK ANY PHOTO-SENSITIVE MEDICATIONS THAT YOU TAKE YOU

Gold or Gold 50	<input type="checkbox"/>	Hostacycline	<input type="checkbox"/>	Chlorpromazine	<input type="checkbox"/>
Fulvicin P/G or Fulvicin U/F	<input type="checkbox"/>	Lymecycline	<input type="checkbox"/>	Grifulvin V or Griseofulvin	<input type="checkbox"/>
Gris-Peg	<input type="checkbox"/>	Sumycin	<input type="checkbox"/>	Grisovin	<input type="checkbox"/>
Demecocycline	<input type="checkbox"/>	Folex	<input type="checkbox"/>	Ledermycin	<input type="checkbox"/>
Doxycycline	<input type="checkbox"/>	Ledertrexate	<input type="checkbox"/>	Cyclidox	<input type="checkbox"/>
Doryx	<input type="checkbox"/>	Methotrexate Sodium	<input type="checkbox"/>	Doxycyl or Doxytab	<input type="checkbox"/>
Dumoxin	<input type="checkbox"/>	PF	<input type="checkbox"/>	Noritet	<input type="checkbox"/>
Viacin	<input type="checkbox"/>	Aratac	<input type="checkbox"/>	Vibramycin	<input type="checkbox"/>
Lymecycline	<input type="checkbox"/>	Pacerone	<input type="checkbox"/>	Minocycline	<input type="checkbox"/>
Tetrasal	<input type="checkbox"/>	Amioderone	<input type="checkbox"/>	Minomycin or Minotabs	<input type="checkbox"/>
Cyclimycin	<input type="checkbox"/>	Codarone X	<input type="checkbox"/>	Terramycin	<input type="checkbox"/>
Oxytetracycline Be-oxytet	<input type="checkbox"/>	Terra-Cortril	<input type="checkbox"/>	Cotet	<input type="checkbox"/>
Oxypan	<input type="checkbox"/>	Trexall	<input type="checkbox"/>	Quinolone Derivatives	<input type="checkbox"/>
Ciprofloxacin	<input type="checkbox"/>	Methotrexate	<input type="checkbox"/>	Nalidixic Acid	<input type="checkbox"/>
Norfloxacin	<input type="checkbox"/>	LPF	<input type="checkbox"/>	Ofloxacin	<input type="checkbox"/>
Tetracycline or Tetracycline	<input type="checkbox"/>	Mexate AQ	<input type="checkbox"/>	Achromycin or Acromysin V	<input type="checkbox"/>
Actisite	<input type="checkbox"/>	Thorazine	<input type="checkbox"/>	Bristacycline	<input type="checkbox"/>
Ciprofloxacin	<input type="checkbox"/>	Tetrex	<input type="checkbox"/>	Helidac	<input type="checkbox"/>
Auranofin	<input type="checkbox"/>	Azathioprine	<input type="checkbox"/>	Chlorpromazine HC	<input type="checkbox"/>
Ridaura	<input type="checkbox"/>	Roaccutane	<input type="checkbox"/>	Largactil	<input type="checkbox"/>
Sonazine	<input type="checkbox"/>	Isotretinoin Accutane	<input type="checkbox"/>		<input type="checkbox"/>

Client Signature _____

Date _____