



**YOUTHFUL BALANCE
MEDICAL CENTER**

10887 N. Military Trail, Suite 7 | Palm Beach Gardens, FL 33410

Ph: 561-537-0537 Fax: 561-370-6843

www.youthfulbalance.net

Cosmetics Patient Medical History Form

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ Male: _____ Female: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Driver's License Number: _____

How did you hear about us: _____

List all medications, including vitamins and supplements that you are taking:

Drug sensitivities and/or drug allergies:

Past Medical History (if none, please put "none"):

Reason for cosmetic evaluation (why you are here):

Previous cosmetic treatments and date(s) of last procedure:

Signature of Patient

Date