

Welcome to EcoNatura SPA a Program of WellnessMD Institute

Henry A. Villegas, MD, FAAP, FAWM, Director

CityState(Province)ZipCountry Home Phone ()Work Phone()Mobil () e-Mail Address: e-Mail Address: I wish to receive GreenLagoon Newsletter/internet special notices. Yes / No Date of Birth/ DccupationName of Massage How did you learn of our SPA & GreenLagoon? (please indicate-circle- all that apply)	Part I Please help us to s	serve you better by con	npleting the Gu	est Information Form
First name Last name Gender Salutation (please indicate one) Mr. / Mrs. / Miss / Dr.	General Information (St	<u>rictly Confidencial)</u>		
Salutation (please indicate one) Mr. / Mrs. / Miss / Dr Address Line 1 Address Line 2 CityState(Province)ZipCountry Home Phone ()	Date mo day yr/	/		
Address Line 1	First name	Last name	<u> </u>	Gender
Address Line 2 City State(Province) Zip Country Home Phone () - Work Phone() - Mobil () - e-Mail Address: - - Mobil () - - e-Mail Address: - - Mobil () - - e-Mail Address: - - - Mobil (_) - e-Mail Address: - - - - - I wish to receive GreenLagoon Newsletter/internet special notices. Yes / No - - - Date of Birth / / - - - Occupation Name of Massage - - - How did you learn of our SPA & GreenLagoon? (please indicate-circle- all that apply) - -	Salutation (please indicat	te one) Mr. / Mrs. / Ms.	/ Miss / Dr	
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Web Site/ Word of Mouth/Online Hotel-SPA Booking Services/Radio/ Yellow pages/Drove by	Web Site/ Word of Mouth	n/Online Hotel-SPA Boo	oking Services/R	adio/ Yellow pages/Drove by
nternet Promotions/A Web link Gift Certificate/Search Engine/	Internet Promotions/A We	eb link Gift Certificate/S	Search Engine	/

Part II For your comfort and safety, please complete the health history information

Health History (Strictly Confidencial)

Have you ever had a reaction to personal care products? Yes N	o If yes, please list
Are you allergic to any medications? If yes, please list	st
Are you taking any medications at present? Yes No l	Please list them
Do you smoke? Yes No If yes, packs per day?	Are you pregnant? Yes No
Do you have a history of any of these health conditio	ns?
High Blood Pressure Yes No Diabetes Yes No Bleedi	ng Problems Yes No Seizure Yes No
Heart Problems Yes No Cancer Yes No Claustrophol	oia Yes No Thyroid Problems Yes No
Skin Condition Yes No Radiating Pain Yes No Blood	l Clots Yes No Arthritis Yes No
Nail Fungus Yes No Systemic Disease Yes No Spinal	Problems Yes No
Varicose Veins Yes No Acute Injury Yes No If yes, p	lease elaborate
Have you ever had surgery? Yes No If yes, please exp	plain
Do you wear contact lenses? Yes No Migraines Yes N	lo
Do you have any other medical conditions of which w	ve should be aware? Yes No
If yes, please list	
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