Client Medical History Form

Date ______________________________________

Birthdate______________________________________

Name____

Address____

Phone____

Emergency Contact____

Email____

Do you have or previously had any of the following: (Circle YES or NO)

YES NO History of MRSA

YES NO Botox (Last Treatment____)

YES NO Diabetes

YES NO Hepatitis A B C D

YES NO Forehead / Brow Lift

YES NO Easy Bleeding

YES NO Facelift

YES NO Alcoholism

YES NO Abnormal Heart Condition

YES NO Take medication before dental work

YES NO Chemical Peel (Last Treatment ____)

YES NO Pregnant Now – Breastfeeding Now

YES NO Brow Lash Tinting

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YES NO Autoimmune Disorder

YES NO Oily Skin

YES NO Cancer (Year ______________________)

YES NO Accutane or Acne Treatment

YES NO Chemotherapy / Radiation

YES NO Tan by booth or salon

YES NO Tumors / Growth / Cysts

YES NO Difficulty numbing with dental work

YES NO Taking blood thinners such as: Aspirin, Ibuprofen, alcohol, coumadin, etc.

YES NO Allergic reaction to any medications such as Lidocaine, Tetracaine, Epinephrine, Dermacaine, Benzyl Alcohol, Carbopol, Lecithin, Propylene Glycol. Vitamin E Acetate, etc.

YES NO Allergic to metals, food, etc________________________

YES NO Any diseases or disorders not listed_______________________________________

YES NO Do you use skin care products containing Retin A, Glycolic Acid, or Alpha Hydroxy?

Please list any medications you are taking____

I agree that all the above information is true and accurate to the best of my knowledge.

Signed____Date_______________________________