CLIENT MEDICAL HISTORY FORM

Date: _____ Birthdate: _____

Name: _____

Address: _____

Phone: _____ Email: _____

Emergency Contact Person: _____ Phone: _____

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
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 Booth or Salon
YES NO Tumors/Growth/Cysts
YES NO Difficulty Numbing with Dental Work
YES NO Taking Blood Thinners Such As: Asprin, 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 Hydrocyl

Please list any medications you are taking: _____

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

Signed: _____ Date: _____