

Client Medical History Form

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_ ZIP\_\_\_\_\_\_\_\_\_\_

Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you presently have or previously had any of the following: (Circle Yes or No)

Yes / No History of MRSA

Yes / No History of epilepsy, seizures, fainting or narcolepsy

Yes / No Botox

Yes / No Diabetes

Yes / No Lip Fillers (Restylane, Juvederm)

Yes / No Cold Sores/ Fever Blisters

Yes / No Blepharoplasty (Eyelid surgery)

Yes / No Hepatitis (A, B, C, D)

Yes / No Forehead/Brow List

Yes / No Easy/Excessive Bleeding

Yes / No Face Lift

Yes / No Alcoholism

Yes / No Eye Surgery/injury/ corneal abrasion

Yes / No Abnormal Heart Condition

Yes / No Medications used such as anticoagulants that thin the blood

Yes / No Contact Lenses

Yes / No Take medications before Dental Work

Yes / No Chemical Peel (Last Treatment \_\_\_\_\_\_\_\_\_\_\_\_\_\_)

Yes / No Skin Sensitivities to soaps, disinfectants, ect.

Yes / No History of allergies or adverse reactions to pigments, dyes, or other skin sensitivities such as, but not limited to latex.

Yes / No Pregnant/ Breastfeeding – Currently

Yes / No Brow or Lash Tinting

Yes / No Autoimmune Disorder (Human Immunodeficiency Virus)

Yes / No Oily Skin

Yes / No Cancer (DATE\_\_\_\_\_\_\_\_\_\_\_)

Yes / No Accutane or Acne Treatment

Yes / No Chemotherapy/ Radiation

Yes / No Tan by booth or natural sun

Yes / No Tumors/Growths/ Cysts

Yes / No Difficulty numbing for 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, Benzyl alcohol, Carbopol, Lecithin, Propylene Glycol, Vitamin E Acetate, etc.

LIST (IF SO) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes / No Allergies to metals, foods, etc. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes / No Any Diseases or disorders not listed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes / No Do you use skin care products containing Retin A, glycolic acid, or alpha hydroxyl?

Please List All Vitamins and Medications you are Currently Taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_