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# CLIENT MEDICAL HISTORY

Name: _____ Date of Birth: _____

Address: _____

Street City State Zip

Home Phone: _____ Business Phone: _____

Cell Phone: _____ May we contact you at these numbers? _____

Email Address: _____ Other ID: _____

Referred by: _____

Emergency Contact: _____ Phone Number: _____

**PROCEDURE(S) DESIRED:** Check all of the following that apply.

- ☐ Upper eyeliner ☐ Partial eyebrows ☐ Lip liner ☐ Beauty mark ☐ Scar revision
- ☐ Lower eyeliner ☐ Full eyebrows ☐ Full lip color ☐ Needling
- ☐ Other: _____

Please list any surgeries: _____

If you are planning cosmetic or other surgeries/procedures in the near future, describe: _____

_____

List all medications, prescription and non-prescription that you have taken in the last two weeks: _____

_____

If you are currently under a physician's care for any condition, describe: _____

Physician's Name: _____ City: _____ Phone: _____