Client History Form

For the best result, please fill up all questions truthfully and thoroughly.					
Name:				Age:	Gender: F / M
Address:				City:	
State: Zip Code:			Occupation:		
Cell phone number:			Contact Email:		
Emergency Contact/relationship:				Emergency Contact #:	
How do you find us: Internet Referral Yelp Social Media Others					
YES	NO	Are you pregnant?	YES	NO	Do you have any prosthetic implants?
YES	NO	Are you nursing now?	YES	NO	Are you sick? (flu or cold.. etc.)
YES	NO	Have you had any alcohol in last 24 hrs?	YES	NO	Are you currently being treated for depression?
YES	NO	Do you have any allergies to latex?	YES	NO	Do you have any type of herpes?
YES	NO	Do you wear contact lenses?	YES	NO	Do you have high or low blood pressure?
YES	NO	Have you had a laser or chemical peel whitin the last 6 months?	YES	NO	Are you undergoing radiation or chemotherapy treatment?
YES	NO	Have you ever had any permanent cosmetics or tattoos done? If so, any complication or problem healing?			
YES	NO	Do you use tobacco? If you use tobacco you may heal slower and this affects the timing of scheduling a touch-up appointment, if applicable.			
YES	NO	Do you rountinely use Retin-A, glycolic, or other exfoliating products?	YES	NO	Have you had botox injections the last 2 months or are you planning on getting it done soon?
YES	NO	Do you have any problem healing?	YES	NO	Do you take Accutane for the last 6 months?
YES	NO	Are you allergic or senstivie to any metals, for instance metals used for jewery?	YES	NO	Do you menstruate? If yes, Next cycle date:
YES	NO	Do you consume aspirin daily? If so, needed to be off the med for at least 7 days prior to the procedure.			
YES	NO	Is your skin oily?	YES	NO	Do you have dry eye?
YES	NO	Are you diabetic? If so, Type 1 or Type 2?	YES	NO	Are you anemic?
YES	NO	Do you have a heart condition?	YES	NO	Do you exercise a lot or regularly?
YES	NO	Are you wearing pacemaker?	YES	NO	Are you allergic to hair dyes?
YES	NO	Do you have a history of stroke or heart attack?	YES	NO	Do you have allergies to makeup?
YES	NO	Are you sensitive or allergic to hand creams/body lotions?	YES	NO	Are you allergic to anesthetic(lidocaine) or epinephrine?
YES	NO	Do you have your lips injected with filler materials?	YES	NO	Are you sensitive to petrolium (such as vaseline) based products?
YES	NO	Did you take Doxycycline in the past 6 months?	YES	NO	Do you have any type of hepatitis?
YES	NO	Do you hypo-pigment? (Lack of pigment on the skin)	YES	NO	Do you have any distory of cancer?
YES	NO	Do you hyper-pigment? (Tendency to develop dark spots on the skin from wounds or sun)?	YES	NO	Any skin irritation near the brow area (such as sunburn, acne, rashes, redness…etc)
YES	NO	Do you tend to develop keloid or hypertrophic scars?	YES	NO	Do you have OCD or anxiety?
YES	NO	Do you scar easily from minor skin injuries?	YES	NO	Do you have auto-immune disorders?
YES	NO	Do you have any seizure related conditions?	YES	NO	Do you have seborrheic dermatitis?
YES	NO	Do you bleed excessively from minor cuts?	YES	NO	Do you have any contagious skin disease?

I understand that the information provided on this form is to ensure the artist can perform the procedure safely and effectively on you. All information will be kept confidential under the HIPPA law. I have confirmed that I have completed this form to the best of my knowledge and understand that if there are any changes to my medical or personal details, I will make the artist aware before another appointment is made.

Client Signature:	Date: