HEALTH HISTORY FORM

Name:_____ DOB:_____ Date:_____

Address:_____ City_____ State:_____ Zip:_____

Phone #:_____ Email:_____ Employer:_____

Emergency Contact Name & Phone #:_____ How did you hear about us?_____

Are you currently under the care of a physician?____yes ____no If so, for what?_____

Physician's name:_____ Physician's phone #:_____

Date of last lab tests or chemistry screening_____ Have you had abnormal lab / test results? ____yes _____no

If so what?_____ Covid? ____yes _____no Vaccine?____yes _____no

Have you ever had injectables, facial treatments or tattoos? _____yes _____no Did you have negative reactions? ____yes _____no

If so what?_____ Allergies:_____

List all current medications:_____

List all supplements /herbs:_____

- Treatment is limited on those who are pregnant, nursing, or have hemophilia, bleeding disorders, allergies to lidocaine &/or epinephrine.
  ____ this does apply to me ____ this does not apply to me
- Treatments are discouraged for those who have auto-immune disorders, diabetes, heart conditions, active dermatological disorders, are highly reactive and allergic, or take medication(s) that thin the blood. These clients may need a doctor's release to undergo procedure.
  ____ this does apply to me ____ this does not apply to me
- For some injectables and permanent cosmetics, patch tests are recommended but are mandatory for those with keloid formations, dermatological disorders, and are highly reactive and allergic. ____ this does apply to me. ____ this does not apply to me
- List all medications you are currently taking including topical medications and Retin A, Retinol, Glycolic Acid & Accutane:

  _____
- Have you recently undergone a skin peel, laser, botox, or other esthetics treatment(s)? If so, please describe:

  _____
- Do you have, or have ever had, any of the following? Please circle

Heart conditions /disease	Cold sores (RX:VALTREX)	Herpes simplex	Pregnant /Breastfeeding	G6PD Deficiency
Hemophilia / bruising	Epilepsy	Glaucoma (NO EYELINER TX)	Mental Disease	Hyperpigmentation
High/low blood pressure	Diabetes	Cataracts	Parathyroid problems	Tanning Bed &/or Sun
Prolonged bleeding	Fainting / dizziness	Corneal abrasion	Strokes	Skin disorders
Circulatory problems	Lupus or other immune disorders	Optic Nerve Atrophy or Leber's Disease	Nuero-Muscular Disorder	Recreational drugs what_____
Tumors/growths/cysts	Hepatitis	Wear glasses or contacts	Sarcoidosis	Smoke / Tobacco
Chemotherapy/radiation	HIV/ AIDS	Eye surgery / injury	Sickle Cell Anemia	Drink alcohol daily
Cancer	Kidney disease or stones	Asthma	Liver Disease	Other:
High Magnesium	High Calcium	Low Potassium	High Iron	

I understand all questions and have answered honestly and am at least 18 years of age ____Yes ____No

Signature:_____ Date:_____

Staff Signature:_____ Date:_____

HIPPA Notice of Receipt of Privacy Practices

I acknowledge that I have been informed and given access to the Notice of Privacy Practices at Monarch Medical Esthetics.

I understand that I may request a hard copy of these notices at any time.

I understand the Notice of Privacy Practices discusses how my Protected Health Information (PHI) may be used/or disclosed, my rights to protected health information, and how and where I may file a privacy related complaint.

Signature:_____ Date:_____

Authorization to Release and Disclose Photographs

I give my permission and voluntarily consent to the copyright, publication, and use of my picture and likeness by Monarch Medical Aesthetics LLC.. By signing this form, I am allowing Monarch Medical Aesthetics to disclose photographs taken of me before, during, and after treatment for use in, but not limited to, educational/ training lectures, advertising and promotions, print, social and/or broadcast media. I understand my name shall not be used in any publication. I hereby release Monarch Medical Aesthetics LLC., from any claim for payment in royalties in connection with any exhibition, demand, cause, action, or proceeding of whatever nature arising out of publication and distribution of these said photographs in accordance with the terms of this release.

(patient initials)_____

Do not use my pictures outside of use in my medical records and educational/training lectures.

(patient initials)_____

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Beautiful Change.