|  |  |  |
| --- | --- | --- |
| Name: | DOB | Date |

|  |  |
| --- | --- |
| Address | Phone |
|  | Email |

|  |  |  |  |
| --- | --- | --- | --- |
| **Previous Medical Conditions/Treatments** | **Yes** | **No** | **Details** |
| Cold Sores? |  |  |  |
| Jaundice, Hepatitis, Liver or Kidney disease? |  |  |  |
| Asthma, Eczema or other allergic disease? |  |  |  |
| Any blood-borne diseases? |  |  |  |
| Angina, murmur, valve or other heart conditions? |  |  |  |
| A stroke or any other blood pressure problems? |  |  |  |
| Any neurological conditions such as epilepsy, Bell’s Palsy, MS, Chorea or Myasthenia Gravis? |  |  |  |
| Allergic to latex, antibiotics, foods, drugs/substances? |  |  |  |
| Any recent vaccinations, cortisone injections or steroids? |  |  |  |
| Replacements, implants, operations, X-rays recently? |  |  |  |
| Any other diseases, illnesses or treatments? |  |  |  |
| Have you ever had cancer? |  |  |  |
| **Current Medical Status** |  |  |  |
| Are you receiving treatment from a doctor, hospital or specialist? |  |  |  |
| Carry a warning card, EpiPen, had anaphylaxis reaction? |  |  |  |
| Taking medicines, pills, tablets, ointments or inhalers? |  |  |  |
| Do you bruise or bleed easily? |  |  |  |
| Any auto-immune disease, including lupus? |  |  |  |
| Any circulative problems or varicose veins? |  |  |  |
| Any endocrine disorders? (diabetes, thyroid) |  |  |  |
| Have you had electrical facial treatments before? |  |  |  |

I have been given the opportunity to ask questions and hereby certify that I have read and fully understood the contents of this consent form. I have received an aftercare sheet and agree to follow the recommendations.

\_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

Practitioner’s Name and Signature Client Signature