Brow Pro

Client Medical History Form

Date: _____
Name: _____
Birth Date: _____
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 Diabetes
Yes / No Cold Sores/ Fever Blisters ever?
Yes / No Hepatitis (A, B, C, D)
Yes / No Easy bleeding
Yes / No Alcoholism
Yes / No Abnormal Heart Condition
Yes / No Take meds before Dental work

Yes / No Botox

Yes / No Lip fillers/ Restylane/Juvederm
Yes / No Blepharoplasty (Eyelid surgery)
Yes / No Forehead/Brow lift
Yes / No Face lift
Yes / No Eye surgery/ injury/ Corneal abrasion
Yes / No Contact Lenses now
Yes / No Chemical Peel
(last treatment)? _____

Yes / No Pregnant now/ Breast feeding now
Yes / No Brow or Lash tinting
Yes / No Autoimmune Disorder
Yes / No Oily Skin
Yes / No Cancer year

Yes / No Accutane or acne treatment
Yes / No Chemotherapy/ Radiation
Yes / No Tan by booth or sun
Yes / No Tumors/ Growths/ Cysts
Yes / No Difficulty numbing with dental work

Yes / No Taking blood thinkers such as: Aspirin, Ibuprofen, alcohol, Coumadin, ect.
Yes / No Allergic reaction to any medications such as: Lidocaine, Tetracaine, Epinephrine, Dermacaine, Benzyl alcohol, Carbopol, Lecithin, Propylene glycol, Vitamin E Acetate, ect.
List: _____
Yes / No Allergies to metals, food, ect.
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 medications or vitamins you're presently taking:
_____

I agree that all the above information is true and accurate to the best of my knowledge.
Signed: _____
Dated: _____