# Boise Microblading and Lashes

**Client Medical History Form**

**Date _____**
**Name_____Birthdate_____**
**Phone_____**
**Email_____**

**Do you have or previously had any of the following: (Circle YES or No)**

**YES NO History of MRSA**
**YES NO Botox (Last treatment must be 2 months )**
**YES NO Diabetes**
**YES NO Hepatitis A B C D**
**YES NO Forehead/Brow Lift**
**YES NO Easy Bleeding**
**YES NO Facelift**
**YES NO Chemical Peel (Last Treatment )**
**YES NO Pregnant now**
**YES NO Brow Lash Tinting**
**YES NO Oily Skin**
**YES NO Accutane or acne treatment**
**YES NO Chemotherapy/ Radiation**
**YES NO Tan by booth or salon**
**YES NO Tumors/ Growth/ Cysts**
**YES NO Taking blood thinners such as: Aspirin, Ibuprofen, or Alcohol**
**YES NO Allergic reaction to any medications such as; Lidocaine, Tetracaine, or Epinephrine**
**YES NO Any diseases or disorders not listed**
**YES NO Do you use skin care products containing Retin A, Glycolic Acid, or Lactic Acid?**
**Please list any medications you are taking:**
**_____**
**I agree that all the above information is true and accurate to the best of my knowledge**

**Signed_____**
**Date_____**