CONFIDENTIAL MEDICAL PROFILE

Client Name: _____ Date of Birth: _____

Age: _____ Address: _____

Phone Number: _____ Email Address: _____

Allergies: _____

Name of today's procedure: _____ Have you had this done before? _____

PLEASE CIRCLE THE ANSWER THAT APPLIES:

YES | NO Are you under the age of 18?
YES | NO Are you pregnant or nursing?
YES | NO Have you had any blood thinning medications in the last 7 days?
YES | NO Have you had any mood altering medications in the last 24 hours?
YES | NO Do you have a history of herpes, cold sores, or fever blisters?
YES | NO Do you have a history of skin disorders or remarkable skin sensitivities?
YES | NO Do you have problems with healing?
YES | NO Have you had this procedure done before?
YES | NO Have you had any previous problems with this procedure?
YES | NO Are you currently undergoing chemotherapy or radiation?
YES | NO Are you currently using Retin-A or alpha-hydroxy skin care products?
YES | NO Have you had a photofacial, laser rejuvenation, or microneedling in the last 30 days?
YES | NO Have you had a chemical peel or microdermabrasion in the past two weeks?
YES | NO Do you wear contacts?
YES | NO Have you ever used Accutane? If so, when did you stop?
_____
YES | NO Do you have a pacemaker or any other metal implants?
YES | NO Do you use any tobacco products?
YES | NO Do you have botox or fillers?
YES | NO Are you anemic?

PLEASE CIRCLE ALL THAT APPLIES:

Heart Disease
Hepatitis
Cancer
Epilepsy
Glaucoma
Alopecia
Dry Eye
Keloids
Stroke
Herpes
Kidney Disease
HIV
Diabetes
Bleeding Disorder
Cold Sores/ Fever Blisters
Trichotillomania
Autoimmune Disorder
Hyper-pigmentation
Hypo-pigmentation

PLEASE LIST ANY AND ALL MEDICAL CONDITIONS AND CURRENT MEDICATIONS.

Practitioner makes no attempt to or claim to practice medicine. Some individuals will have complications related to permanent makeup application, microneedling, nano-infusion or chemical peels. These complications are usually mild and last only a few days. However, extreme complications are always a possibility. By signing this consent, you are acknowledging that you are in good health and there are no apparent reasons to restrict you from receiving today's treatment.

Client Signature_____ Date_____