CLIENT MEDICAL HISTORY FORM

Name________________Birthdate___________Date__________

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

YES NO History of MRSA

YES NO Rosacea

YES NO Botox/Filler (Last treatment_______________________________)

YES NO Diabetes

YES NO Hepatitis A B C D

YES NO Forehead/Brow Lift

YES NO Easy Bleeding

YES NO Facelift

YES NO Abnormal Heart Condition

YES NO Take medication before dental work

YES NO Chemical Peel (Last Treatment________________________)

YES NO Pregnant now or Breastfeeding now

YES NO Brow Lash Tinting

YES NO Autoimmune disorder

YES NO Oily Skin

YES NO Cancer

YES NO Accutane or acne treatment

YES NO Chemotherapy/ Radiation

YES NO Tan by booth

YES NO Tumors/ Growth/ Cysts

YES NO Prone to over growth of scar tissue (history of keloids)

YES NO Difficulty numbing with dental work

YES NO Taking blood thinners such as: Aspirin, Ibuprofen, Alcohol, Coumadin etc

YES NO Allergic reaction to any medications such as Lidocaine, Tetracaine, Epinephrine, Benzyl Alcohol, Carbopol, Lecithin, Propylene Glycol, Vitamin E Acetate, etc.
LIST________________________________

YES NO Allergies to metals, food, etc____

YES NO Any diseases or disorders not listed____

YES NO Do you use skin care products containing Retin-A, Glycolic Acid, or Alpha Hydroxyl?

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

Signed____Date____________