Client Information & Medical History Form

NAME: _____DATE OF BIRTH: _____

ADDRESS:___ _____

PHONE:_____

EMAIL:_____

Emergency Contact Person:_____Phone_____

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

YES NO	History of MRSA
YES NO	Botox/Fillers (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	Alcoholism
YES NO	Abnormal Heart Condition
YES NO	Take medication before dental work
YES NO	Difficulty numbing with 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	Scarring (Keloids)
YES NO	Skin Problems (Eczema, Psoriasis, etc.)
YES NO	Hemophilia

YES NO Eye Problems

YES NO Epilepsy

YES NO Jaundice

YES NO Oily Skin

YES NO Cancer (Last Treatment_____)

YES NO Accutane or Acne Treatment

YES NO Chemotherapy/Radiation(When_____)

YES NO Tan by booth or salon

YES NO Tumors/ Growths/ Cysts

YES NO Do you wear contact lenses

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

YES NO Allergic reactions to any medications such as Lidocaine, Tetracaine, Epinephrine, Dermacaine, Benzyl Alcohol, Carbopol, Lecithin, Propylene Glycol, Vitamin Acetate, Etc.

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

YES NO 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_____