

## Client Medical History Form

Date \_\_\_\_\_ Birthdate \_\_\_\_\_

Name \_\_\_\_\_

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 (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** Chemical Peel (Last Treatment \_\_\_\_\_)

**YES NO** Pregnant now – Breastfeeding now

**YES NO** Brow 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 salon

**YES NO** Tumors/ Growth/ Cysts

**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, Dermacaine, Benzyl Alcohol, Carbopol, Lecithin, Propylene Glycol, Vitamin E 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?

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 \_\_\_\_\_