Client Medical History Form

Date_____Birthdate_____

Name_____

Address_____

Phone_____Email_____

Emergency Contact Person_____Phone_____

Do you have or previously had any of the following: (Cirlce 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_____