CLIENT MEDICAL HISTORY FORM

Name _____ **Birthday** ___/___/___ **Todays Date** ___/___/___

Street _____ **City** _____ **State** _____ **Zipcode** _____

Email _____ **Phone** (___) ___- _____ ☐ **cell** *or* ☐ **landline**

Emergency Contact _____ **Phone** (___) ___- _____ ☐ **cell** *or* ☐ **landline**

Primary Care Doctor _____ **Phone** (___) ___- _____

DO YOU PRESENTLY HAVE, OR HAVE YOU PREVIOUSLY HAD, ANY OF THE FOLLOWING? Please check Y (Yes) or N (No).

Y	N		Y	N		If "Yes", Last Date
☐	☐	DIABETES	☐	☐	BOTOX	___/___/___
☐	☐	COLD SORES / FEVER BLISTERS *(Ever?)*	☐	☐	LIP FILLER / RESTYLANE / JEVE DERM	___/___/___
☐	☐	HEPATITIS A, B, C or D	☐	☐	CHEMICAL PEEL	___/___/___
☐	☐	EASY BLEEDING	☐	☐	FACE LIFT	
☐	☐	ALCOHOLISM	☐	☐	BROW LIFT	
☐	☐	HEART CONDITION	☐	☐	EYE SURGERY / INJURY / CORNEAL ABRASION	
☐	☐	PREGNANCY *(NOW)* / BREAST FEEDING *(NOW)*	☐	☐	BLEPHAROPLASTY *(Eyelid Surgery)*	
☐	☐	OILY SKIN	☐	☐	BROW OR LASH TINTING	
☐	☐	TAN BY BOOTH OR SUN	☐	☐	DIFFICULTLY NUMBING WITH DENTAL WORK	
☐	☐	ACCUTANE OR OTHER ACNE TREATMENT	☐	☐	CONTACT LENSES *(Wearing now?)*	

☐ ☐ BLOOD THINNERS: Aspirin, Ibuprofen, Alcohol, Eliquis, Coumadin, Other? _____

☐ ☐ ALLERGIC REACTIONS to medications such as Lidocaine, Benzyl Alcohol, Vitamin E Acetate or related medications.
If **Yes**, list _____

☐ ☐ Allergies to Metals, Foods, etc. If **Yes**, list please _____

☐ ☐ Any Diseases or Disorders not listed above? _____

☐ ☐ Do you use skin care products containing Retin-A, Glycolic Acid or Alpha Hydroxyl?

Please list all Medications, Vitamins and Supplements you are currently taking. _____

_____

I AGREE THAT ALL THE ABOVE IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

SIGNATURE: _____ **DATE:** _____