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 Thyroid Conditions
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 Keloids
YES NO Large Pores
YES NO Frequent Sweating (Extensive Exercising)
YES NO Take medication before dental work
YES NO Chemical Peel (Last Treatment_____)
YES NO Pregnant now – Breastfeeding now
YES NO Menopause
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_____