Client Medical History Form

Date ______________________________ Birthdate ________________________________

Name ____

Address ____

Phone ____

Emergency Contact Name _______________________Phone # ____________________________

Email ____

Are you now or have you been under the care of a physician within the last 2 years? ❒ Yes ❒ No

If yes, your Physician's name, address, and phone number___________________________________

List all medications that you are currently taking. ____

____

Are you taking or using Retin A, Glycolic Acid & Accutane? ____________________________________

List any drugs, makeup, skin, or food allergies (i.e. soap or cleaning creams)_________________________

____

Have you recently undergone a skin peel? (When/Where) ______________________________________

What product(s) are you using for skin care? ____

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

YES	**NO**	History of MRSA	**YES**	**NO**	Eye Surgery or Injury
YES	**NO**	Diabetes	**YES**	**NO**	Blepharoplasty (Eyelid Surgery)
YES	**NO**	Hepatitis A B C D	**YES**	**NO**	Visual Disturbances
YES	**NO**	Cold Sores	**YES**	**NO**	Corneal Abrasions
YES	**NO**	Herpes Simplex	**YES**	**NO**	Cataracts
YES	**NO**	Hemophilia	**YES**	**NO**	Fainting Spells/Dizziness
YES	**NO**	Glaucoma	**YES**	**NO**	Epilepsy
YES	**NO**	High or Low Blood Pressure	**YES**	**NO**	Easy Bleeding or Prolong Bleeding
YES	**NO**	Forehead/Brow Lift	**YES**	**NO**	Facelift
YES	**NO**	Abnormal Heart Condition	**YES**	**NO**	Pregnant Now - Breastfeeding Now
YES	**NO**	Take Med Before Dental Work	**YES**	**NO**	Brow Lash Tinting
YES	**NO**	Difficulty numbing (Dental Work)	**YES**	**NO**	Oily Skin
YES	**NO**	Autoimmune Disorder	**YES**	**NO**	Accutane or Acne Treatment
YES	**NO**	Cancer (Year) ______________	**YES**	**NO**	Tumors / Growth / Cysts
YES	**NO**	Chemotherapy / Radiation	**YES**	**NO**	Using Eye Drops or Ocular Meds

Signed ____ Date ______________

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Client Medical History Form Cont'd

YES **NO** Allergic reaction to any medications such as Lidocaine, Tetracaine, Epinephrine,
YES **NO** Dermacine, Benzyl Alcohol, Carbopol, Lecithin, Propylene Glycol, Vitamin E Acetate, etc.
Chemical Peel
Last Treatment Date: ____

YES **NO** Botox (Last Treatment Date) ____

YES **NO** Tan by booth or salon (When?) ____

YES **NO** Allergic to metals, food, etc. ____
YES **NO** Taking blood thinners such as Aspirin, Ibuprofen, Alcohol, Coumadin, etc.
YES **NO** Do you use skincare products containing Retin A, Glycolic Acid, or Alpha Hydroxy?
YES **NO** Have you ever experienced hyperpigmentation from an injury?
YES **NO** Any diseases or disorders not listed ____

When was your last eye exam? ____

Eye Physician Name ____

Eye Physician Phone Number ____

Please initial below:

________ I understand that if I have an infection, adverse reaction, or allergic reaction to the procedure, I should notify my physician right away.

________ I have been advised that a touch up session is highly recommended to make any adjustments to the shape, color, and to fill in any pigment that may have had poor retention. I understand that an initial touch up must be completed within 60 days of the initial procedure.

________ I agree that all the information that I have provided in this document is true and accurate to the best of my knowledge.

________ I certify that I have read and have had read to consents of this form. I understand the risks and alternatives involved in this procedure(s). I have had the opportunity to ask questions, and all of my questions have been answered. I acknowledge that I have reviewed and approved the material given to me, and I authorize my Specialist / Technician to perform on my body the procedure that I desire today.

Signed ____ Date _______________