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, HIV
YES NO Forehead/Brow Lift
YES NO Easy Bleeding

YES NO History of Herpes, cold sores, fever blisters?
YES NO Do you wear contact lenses?
YES NO Do you wear eye lash extensions?
YES NO Dry Eyes,Glaucoma,Refractive Eyesurgery
YES NO Trichotillomania

YES NO Facelift
YES NO Alcoholism
YES NO Abnormal Heart Condition
YES NO Take medication before dental work
YES NO 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, 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 AlphaHydroxyl?
YES NO Do you use lash growth serums?
YES NO History of skin issues such as Hyper-/Hypopigmentation, Keratosis, Dermatitis, Rosacea, Psoriasis?
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_____
_____