Client Medical History Form

Date _____ Birthdate_____

Name _____

Address _____

Phone _____ Email _____

Emergency Contact _____ Phone _____

Do you have or previously had any of the following: (Circle 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 Facelift
YES NO Easy Bleeding
YES NO Chemical Peel (Last treatment: _____)
YES NO Pregnant or breast feeding currently
YES NO Brow Tinting
YES NO Autoimmune Disorder
YES NO Oily Skin
YES NO Cancer
YES NO Accutane or Acne Treatment
YES NO Tanning
YES NO Use of blood thinners (Ibuprofen, Alcohol, Aspirin, etc)
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_____