STUDIO420BROWS

CLIENT MEDICAL HISTORY

Date ______________________________ Birth Date ___________________________________

NAME ____

Address ____

City _______________________________ State ____________ Zip _______________________

Email ____ Phone ________________________

Emergency Contact _______________________________ Phone ________________________

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

Yes No History of MRSA
Yes No Botox
Yes No Diabetes
Yes No Lip Fillers / Restylane / Juvederm
Yes No Cold Sores / Fever Blisters
Yes No Blepharoplasty (Eyelid Surgery)
Yes No Hepatitis (A, B, C D)
Yes No Forehead / Brow Lift
Yes No Easy Bleeding
Yes No Alcoholism
Yes No Brow / Lash Tinting
Yes No Eye Surgery / Injury / Corneal Abrasion
Yes No Chemical Peel (Last Treatment __________________)
Yes No Taking Blood Thinners - Aspirin, Ibuprofen, Alcohol, Coumadin, etc. _______________________
Yes No Allergic Reactions to any medications - Lidocaine, Tetracaine, Epinephrine, Dermacaine, Benzyl Alcohol, Carbopol, Lecithin, Propylen Glycol, Vitamin E, Acetate, etc.? ______________________
Yes No Allergies to metals, latex, 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?

Yes No Pregnant / Breastfeeding Now
Yes No Abnormal Heart Condition
Yes No Autoimmune Disorder
Yes No Take Meds before Dental work
Yes No Cancer - What Year _____________
Yes No Accutane or Acne Treatment
Yes No Chemotherapy / Radiation
Yes No Tanning by Booth or Sun
Yes No Tumors / Growths / Cysts
Yes No Difficulty Numbing w/ Dental
Yes No Oily Skin

Please list medications or vitamins you're currently taking: ______________________________
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I agree that all the above information is true and accurate to the best of my knowledge.

Signed ____ Date ____________________

Updated 12/17/18 KC