



STUDIO420BROWS

CLIENT MEDICAL HISTORY

NAME _____ Birth Date _____ Age _____

Driver's License # OR other I.D. _____

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 Pregnant / Breastfeeding Now |
| Yes No Botox | Yes No Abnormal Heart Condition |
| Yes No Diabetes | Yes No Autoimmune Disorder |
| Yes No Lip Fillers / Restylane / Juvederm | Yes No Take Meds before Dental work |
| Yes No Cold Sores / Fever Blisters | Yes No Cancer - What Year _____ |
| Yes No Blepharoplasty (Eyelid Surgery) | Yes No Accutane or Acne Treatment |
| Yes No Hepatitis (A, B, C D) | Yes No Chemotherapy / Radiation |
| Yes No Forehead / Brow Lift | Yes No Tanning by Booth or Sun |
| Yes No Easy Bleeding | Yes No Tumors / Growths / Cysts |
| Yes No Alcoholism | Yes No Difficulty Numbing w/ Dental |
| Yes No Brow / Lash Tinting | Yes No Oily Skin |
| 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? | |

Please list medications or vitamins you're currently taking: _____

I agree that all the above information is true and accurate to the best of my knowledge.

Signed _____ Date _____