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 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 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

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 _____