MEDICAL HISTORY FORM

Name: _____ Birthdate: _____/_____/_____

Street Address: _____

City: _____ State: _____ Zip: _____

Emergency Contact Name: _____ Phone: _____

Do you have or previously had any of the following:

Yes ❒ No ❒ History of MRSA
Yes ❒ No ❒ Diabetes – Type 1 ❒ Type 2 ❒
Yes ❒ No ❒ Hepatitis (Please list type) _____
Yes ❒ No ❒ Abnormal Heart Condition
Yes ❒ No ❒ Anemia
Yes ❒ No ❒ Alcoholism
Yes ❒ No ❒ Autoimmune Disorder _____
Yes ❒ No ❒ Bruise or Bleed easily
Yes ❒ No ❒ Cancer Type: _____
Yes ❒ No ❒ Chemotherapy/Radiation – Last Treatment: _____
Yes ❒ No ❒ Kidney Disorders
Yes ❒ No ❒ Thyroid Condition
Yes ❒ No ❒ Taking prescription blood thinners (Coumadin, Eliquis, Xarelto, etc.)
Yes ❒ No ❒ Taking OTC blood thinners (aspirin, fish oil, vitamin E, etc.)
Yes ❒ No ❒ Currently Pregnant and Breastfeeding
Yes ❒ No ❒ Allergic reaction to Lidocaine, Tetracaine, Benzocaine, etc. (numbing creams)
Yes ❒ No ❒ Allergy to Latex
Yes ❒ No ❒ Any diseases or conditions not listed _____

Please list all known allergies (food, medications, metals, etc.): _____

_____

Please list any medications you are currently taking: _____

_____

Yes ❒ No ❒ Botox (Date of last treatment): _____
Yes ❒ No ❒ Chemical Peel (Date of last treatment): _____
Yes ❒ No ❒ Brow and Lash Tinting
Yes ❒ No ❒ Accutane or Acne Treatment
Yes ❒ No ❒ Skin conditions such as Eczema, Psoriasis, Dermatitis, or Chronic Acne on the head especially the brown or scalp area
Yes ❒ No ❒ Current tanning bed use
Yes ❒ No ❒ Use of skincare products containing Retin-A, Glycolic Acid, Alpha Hydroxyl

Signature _____ Date: _____