Medical History Form

Name: _____ Birthdate: _____/_____/_____

Street Address: _____

City: _____ State: _____

Emergency Contact Name: _____ Ph

Do you have previously had an following

Yes ❒ No ❒ History of M

Yes ❒ No ❒ Diabetes –

Yes ❒ No ❒ Hepatitis (P

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,

Yes ❒ No ❒ Taking OTC blood thinners (aspirin, fish oil, vita etc.)

Yes ❒ No ❒ Currently Pregnant and Breastfeeding

Yes ❒ No ❒ Allergic reaction to Lidocaine, Tetracaine, Benzo e, etc. (num 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, Derm or Chro 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: _____

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