**Client Medical History Form**

**Date\_\_\_\_\_\_\_\_\_\_\_ Birth Date\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_ DL or ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_Zip\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Emergency contact person\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you presently have or previously had any of the following: (Circle yes or no)**

**Yes No** History of MRSA  
**Yes No** Botox (last treatment\_\_\_\_\_\_\_\_)  
**Yes No** Diabetes  
**Yes No** Hepatitis (A,B,C,D)  
**Yes No** Forehead/Brow lift  
**Yes No** Easy bleeding  
**Yes No** Face lift  
**Yes No** Alcoholism  
**Yes No** Abnormal Heart Condition  
**Yes No** Take meds before Dental work  
**Yes No** Chemical Peel (last treatment\_\_\_\_\_\_\_\_)  
**Yes No** Pregnant now/ Breast feeding now  
**Yes No** Brow or Lash tinting  
**Yes No** Autoimmune Disorder  
**Yes No** Oily Skin  
**Yes No** Cancer year\_\_\_\_\_  
**Yes No** Accutane or acne treatment  
**Yes No** Chemotherapy/ Radiation

**Yes No** Tan by booth or sun  
**Yes No** Tumors/ Growths/ Cysts  
**Yes No** Difficulty numbing with dental work

**Yes No** Taking blood thinnners such as: Aspirin, Ibuprofen, alcohol, Coumadin, ect. \_\_\_\_\_\_\_\_\_\_\_\_

**Yes No** Allergic reaction to any medications such as Lidocaine, Tetracaine, Epinephrine, Dermacaine, Benzyl alcohol, Carbopol, Lecithin, Propylene glycol, Vitamin E Acetate, ect. List\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Yes No** Allergies to metals, food, ect.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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 medication or vitamins you’re presently taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Client’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Color Selected for client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**