CLIENT MEDICAL HISTORY FORM

Name ______________________________ Today's Date ____________________

Do you have or previously had any of the following (Circle YES or NO)

YES NO Eczema or Psoriasis on any part of your face
YES NO Scars that Keloid
YES NO Scars heal dark
YES NO Oily skin
YES NO Bleed easily
YES NO Tan by booth or Sun. Last tanned ____________________
YES NO Using Accutane or acne treatments
YES NO Chemical peel. Last treatment ____________________
YES NO Botox or fillers. Last treatment ____________________
YES NO Diabetes
YES NO Hepatitis
YES NO HIV
YES NO Facelift
YES NO Forehead/Brow lift
YES NO Alcoholism or drug addiction
YES NO Abnormal heart condition
YES NO Take medication before dental work
YES NO Have difficulty numbing before dental work
YES NO Pregnant or breastfeeding
YES NO Autoimmune disorder
YES NO Cancer . Year
YES NO Chemotherapy/ Radiation
YES NO Hypoglycemic
YES NO Blood thinners such as: Aspirin, Ibuprofen, Coumadin, etc
YES NO Allergic reaction to any medications such as Lidocaine, tetracaine, Epinephrine, Dermacaine, Benzyl alcohol, Propylene glycol, vitamin E or any medications not listed.
List
YES NO Allergies to metals, food, etc.
YES NO Any diseases or disorders not listed
YES NO Skin care products containing Retyn-A, Glycolic Acid, or Alpha hydroxy
List any medications you are taking:

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

Signed ______________________________ Date ____________________