Client Health Questionnaire

Do you currenty have, or have you previously had, any of the following?
(Please circle YES or NO.)

YES NO History of MRSA
YES NO Botox (Last treatment date_____)
YES NO Chemical peel (Last tretment date_____)
YES NO Forehead/Brow Lift
YES NO Facelift
YES NO Eyebrow tinting
YES NO Oily skin
YES NO Accutane or acne treatment
YES NO Chronic skin disease, including psoriasis, eczema, and rosacea
YES NO Autoimmune disorder
YES NO Do you use skin care products containing Retin-A, Glycolic Acid, or Alpha Hydroxyl?
YES NO Do you have tendency to Keloid (prone to scarring)
YES NO Cancer (year_____)
YES NO Chemotherapy/ Radiation
YES NO Tumors/ Growth/ Cysts
YES NO Epilepsy
YES NO Thyroid disease
YES NO Diabetes
YES NO Hepatitis A B C E
YES NO Easy bleeding
YES NO Abnormal Heart Condition
YES NO Take blood thinners such as: Aspirin, Ibuprofen, alcohol, Coumadin, etc.
YES NO Take medication before dental work
YES NO Difficulty numbing with dental work
YES NO Currently pregnant or breastfeeding
YES NO Allergic reaction to any medications such as Lidocaine, Tetracaine, Epinephrine, Dermacaine, Benzyl Alcohol, Carbopol, Lecithin, Propylene Glycol, Vitamin E Acetate, etc._____

YES NO Allergies to metals, food, hair dyes, etc._____

YES NO Any diseases or conditions not listed_____

Please list any medications you are taking_____

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

Name: _____ Date of Birth:_____

Signed: _____

Date: _____