CLIENT HISTORY FORM

Name	Date	Gender Female / Male	Age
Address	City	State	Zip
Employer / Occupation	Home Phone	Cell Phone	
How did you select me for your procedure services?	E-Mail		

1	YES	NO	Are you pregnant or nursing?	27	YES	NO	Do you have prosthetic implants?
2	YES	NO	Have you had any alcohol in the last 24 hours?	28	YES	NO	Do you consume aspirin daily?
3	YES	NO	Have you ever had cold sores or fever blisters?	29	YES	NO	Are you under treatment for depression?
4	YES	NO	Do you have any allergies to latex?	30	YES	NO	Do you have any type of herpes?
5	YES	NO	Have you had a laser or chemical peel within 6 months?	31	YES	NO	Are you sensitive to petroleum based products?
6	YES	NO	Have you ever had any permanent cosmetics or tattoos applied?	32	YES	NO	If you have permanent cosmetics or tattoos, did you have any problems with healing after they were applied?
7	YES	NO	Do you bruise easily for no obvious reason?	33	YES	NO	Are you undergoing radiation or chemo-therapy treatment?
8	YES	NO	Do you routinely use Retin-A, glycolic, or other exfoliating products?	34	YES	NO	Are you now, or have you ever been on the acne treatment Accutane?
9	YES	NO	Do you wear contact lenses?	35	YES	NO	Are you wearing a pacemaker?
10	YES	NO	Are you allergic or sensitive to any metals, for instance metals used for jewelry?	36	YES	NO	Do you take prescription drugs?
11	YES	NO	Do you have any problems healing?	37	YES	NO	Are you anemic?
12	YES	NO	Is your skin oily?	38	YES	NO	Do you have a history of skin sensitivities?
13	YES	NO	Do you use tobacco? If you use tobacco you may heal slower and this affects the timing on scheduling a touchup appointment, if applicable.	39	YES	NO	Do you have any medical condition that has resulted in a medical professional requiring you to pre-medicate with an antibiotic prior to a dental or other invasive procedures?
14	YES	NO	Do you have any heart conditions?	40	YES	NO	Do you have allergies to makeup?
15	YES	NO	Are you diabetic? If so, Type 1 or Type 2?	41	YES	NO	Do you have dry eyes?
16	YES	NO	Do you have any autoimmune disorders?	42	YES	NO	Do you intentionally tan – Direct sun or tanning bed?
17	YES	NO	Are you sensitive or allergic to hand creams or body lotions?	43	YES	NO	Do you personally have any history of cancer?
18	YES	NO	Do you have your lips injected with filler materials?	44	YES	NO	Do you have a history of stroke or heart attack?
19	YES	NO	Do you have botox injections?	45	YES	NO	To your knowledge are you allergic or resistant to over the counter level numbing products such as ELA-Max?
20	YES	NO	Do you menstruate? If yes: Next cycle date_____	46	YES	NO	Do you hypo-pigment? (Lack of pigment on the skin)?
21	YES	NO	Do you hyper-pigment? (Tendency to develop dark spots on the skin from wounds or sun)?	47	YES	NO	Are you allergic to hair dyes?
22	YES	NO	Do you tend to develop keloid or hypertrophy scars?	48	YES	NO	Do you have glaucoma or any other eye disease?
23	YES	NO	Do you scar easily from minor skin injuries?	49	YES	NO	Do you have arthritis?
24	YES	NO	Do you have any seizure related conditions?	50	YES	NO	Do you have high or low blood pressure?
25	YES	NO	Do you have a tendency to faint or become dizzy?	51	YES	NO	Do you have sinus problems?
26	YES	NO	Do you bleed excessively from minor cuts?	52	YES	NO	Have you experienced Hepatitis or Jaundice during the past 12 months?

If you answered "Yes" to any questions above, use the reverse side of this form to provide an explanation. Correlate your explanations to a specific question number. A "yes" answer does not indicate you are not an acceptable candidate for permanent cosmetics. It may simply be information that is valuable to me as your technician as each person's body is unique, or it may indicate that based on any health conditions that affect healing, it would be advisable or required for you to consult with your physician before proceeding. If this form has not addressed a medical condition you have, please list it on the back.

Client Signature_____ Date_____