Health History

Name_____ Date of Birth_____Date_____

Address_____ City_____ State____ Zip_____

Home Phone (___)_____Work Phone (___)_____ Alt. Phone (___)_____

Whom may we thank for referring you?_____

Emergency Contact_____ Phone(___)_____

Ethnic Background, please incl. all nationalities_____

Procedure(s) desired: Brows___ Eyeliner___ Lip liner___ Full Lip Color___

Fee $_____ $_____ $_____ $_____

ALLERGIES
(Please check if you've ever had an allergic reaction to any of the following, and describe reaction)
Novocain__ Lidocaine__ Epinephrine__ Tetracaine__ Benzocaine__ Latex Rubber__
Cosmetics__ Seasonal (trees, pollen, hay fever)__ Other allergies (food, medicines, etc)__

GENERAL MEDICAL (Check all that apply and describe if "yes")

	YES	NO
Are you on a blood thinning or anticoagulant medication? (i.e. Aspirin, Ibuprofen, Coumadin or alcohol)		
Are you pregnant or nursing?		
Do you have glaucoma or other eye diseases or disorders?		
Have you had laser surgery?		
Are you prone to eye infections? (i.e. conjunctivitis/ pink eye)		
Have you ever had any eye trauma		
Do you have dry eyes?		
Do you have thyroid abnormalities?		
Any kind of heart condition?		
Do you bruise or bleed easily?		
Do you have asthma, emphysema, TB, or other lung diseases?		
Do you have a healing problem?		
Are you diabetic?		
Do you have seizures?		
Are you on Lithium?		
Are you on Accutane, or have you taken it within the last six months?		
Are you on steroids or anti-inflammatory medications?		
Do you use Retin-A or Glycolic Acid?		
Are you iron deficient?		
Do you have any tattoos? Have they caused any problems? If yes, please explain:		

Have you had a perm. cosmetic procedure before? If yes, what procedure and how long ago? Were you pleased w/ the results? If not, please explain:		
Do you have hemophilia or other blood clotting disorders?		
Have you ever had hepatitis? When were you tested?		
Do you have an auto-immune disorder?		
Are you currently undergoing radiation therapy or chemotherapy?		
Any surgeries? If yes, please describe:		
Do you have any dermatologic disorders? Is this disorder presently active?		
Do you have any keloids? (raised, lumpy scarring)		
Do your scars heal in a raised manner?		
Do your scars heal in a darker color?		
Have you ever had a fever blister, cold sore, or canker sore? (for lip procedures only)		
Do you have any pre-existing nerve damage?		
Do you have Alopecia universalis (total) or Alopecia areata (local)?		
Do you pull out your eyelashes or eyebrows?		
Do you wear contact lenses or eyeglasses?		
Do you wear dentures? (for lip procedures only)		
Are your lips chapped? (for lip procedures only)		
Have you had any other aesthetic procedures, even in the form of cosmetic surgery? If yes, where? Are you happy w/ the results?		
Are you planning cosmetic surgery in the future? If yes, please describe:		
Have you ever had a chemical peel? What type of peel?		
Do you use a sunlamp or tanning bed?		
Are you currently tan in the area(s) to be treated?		
Do you practice any outdoor activities regularly? If yes, circle which ones: Tennis Golf Gardening Boating Swimming Skiing Other		

If you are presently under a physician's care for any condition, please describe_____

_____

Physician's name & address_____ Phone (___)_____