History Form

Name: ______________________ Date: ____________ Best Phone Number: _________________

Email: ____

Any Medical Conditions: **Smoke?:** _______ **Drink?** ______

History of Fainting? ___
Diabetes? ___
Epilepsy? ___
Skin Disorders:
Eczema? ___
Psoriasis? ___
Keloids/Scars? ___
Herpes Cold Sores? ___
Herpes Genital? ___
Skin Cancer? ___
Permanent Make-up? ___

Numbness or stroke symptoms? ___
Pace Maker? ___
Pregnant/Nursing? ___
Thyroid Disease? ___
Heart Disease? ___
High Blood Pressure? ___
Lupus? ___
Hepatitis (A,B, or C) ___
Headaches ___
Asthma? ___
Bell's Palsey ___

Medications Used Currently: _________________________

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____

Have you used in past?
Accutane? ___ When Stopped? _______
Renuva/Retin A? ___
Antibiotics – Tetracycline, Doxycycline? ___
Coumadin? ___
Glycolic Acid? ___
Hydroquinone (Bleeding Agent) ___

Allergies: ____

____

Have you had any skin care or cosmetic treatment? ____________________________________

Waxing? ___ **Electrolysis?** ___ **Chemical Peels?** ___

Recent Sun Exposure? Yes ___ No ___
Tanning Bed? Yes ___ No ___
Sunless Tan? Yes ___ No ___