Cosmetic Invasive Procedures require a thorough Medical History. Place an (X) next to any that apply to you.

Your First & Last Name:

Age:\_\_\_\_ Address:\_\_\_\_\_\_\_\_\_\_\_

Cell #

Home#

Work #

Email:

Emergency Contact:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ph#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physicians:

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ph #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you under a Doctor’s Care? YES\_\_\_\_\_\_\_\_NO\_\_\_\_\_\_\_\_\_

Please Explain:

Single\_\_\_\_\_\_Married\_\_\_\_\_\_\_\_

(If married, does your spouse know you are having this treatment done?)

YES\_\_\_\_\_\_\_\_\_\_NO\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_Have you taken any medication today?

\_\_\_\_\_Have you had Lasik Eye Surgery?

Do you have any tattoos?

YES\_\_\_\_\_\_\_\_\_NO\_\_\_\_\_\_\_\_

Any prior permanent makeup?

YES\_\_\_\_\_\_\_\_NO\_\_\_\_\_\_\_\_

**EYES**

\_\_\_Dry Eyes

\_\_\_Contact Lenses

\_\_\_Glasses

\_\_\_Corneal Abrasion

\_\_\_Eye drops or Ocular

 Medication

\_\_\_Eyelid Surgery

\_\_\_Glaucoma/Cataracts

\_\_\_Visual Disturbances

\_\_\_Light Sensitive

\_\_\_Eye Infection

\_\_\_Blepharitis (Eyelids)

**SKIN**

\_\_\_Skin Cancer

\_\_\_Moles\_\_\_Rosacea\_\_\_Scars

\_\_\_Acne\_\_Vitiligo\_\_\_Psoriasis

\_\_\_Do you heal normally?

\_\_\_Retin-A or Accutane

\_\_\_Chemical Peels

\_\_\_Allergies to Makeup

\_\_\_Plastic Surgery

\_\_\_Birthmarks

\_\_\_Laser Treatments

\_\_\_Cosmetic Surgery

\_\_\_Hyperpigmentation (darker)

\_\_\_Hypopigmentation (lighter)

**LIPS**

\_\_\_Cold sores? If yes, how often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Any problems at Dentist office?

\_\_\_Does it take more to get you numb than most people?

\_\_\_Do you take antibiotics when you go to the Dentist?

\_\_\_Do you smoke cigarettes?

\_\_\_Other? Please describe

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ALLERGIES**

\_\_\_None I know of

**ALLERGIES – Continued**

\_\_\_Local Anesthetic

Please List:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Penicillin/Sulfa

\_\_\_Nickel

\_\_\_Hair Coloring

\_\_\_Codeine or Demerol

\_\_\_Bee Sting/Insect Bite Allergy

\_\_\_Makeup/Mascara, etc.

\_\_\_Sunscreens with PABA

\_\_\_Other, Please explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICATIONS**

\_\_\_None

\_\_\_Vitamins/Herbs

\_\_\_Chemotherapy/Radiation

\_\_\_Aspirin

\_\_\_Benadryl or Allegra

\_\_\_Ibuprofen (Advil or Aleve)

\_\_\_Accutane or Retin-A

\_\_\_Hormones

\_\_\_High Blood Pressure

\_\_\_Heart Pills

\_\_\_Water Pills

\_\_\_Pain Pills

\_\_\_Tranquilizers

\_\_\_Anti-Depressants

\_\_\_Blood Thinners

\_\_\_Thyroid Medication

\_\_\_Insulin (Diabetes)

\_\_\_Fever Blister Medication

**GENERAL HEALTH**

\_\_\_Alopecia (hair loss)

\_\_\_Anemia \_\_\_Arthritis

\_\_\_Cancer \_\_\_Lupus

\_\_\_Hepatitis or HIV

\_\_\_Seizures or dizziness

\_\_\_Depression\_\_\_Headaches

\_\_\_Mitral Valve Prolapse

\_\_\_Sugar Diabetes

\_\_\_High Blood Pressure

\_\_\_Asthma \_\_\_Heart

\_\_\_Eye Problems

\_\_\_Liver \_\_\_Kidney

\_\_\_Pregnant/Nursing

**Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**