CLIENT INFORMATION/MEDICAL HISTORY

Name ______________________________________Age_________ Date__________

Address___________________________City__________________State_____Zip________

Email Address____

Cell_________________________________ Date of Birth ______________________________

Emergency Contact________________________Relationship_____________Cell____________

Medications (Prescriptions/over the counter med, vitamins, herbal medications)

____

____

Drug Allergies____

Major Surgeries/Facial surgeries____

Ongoing facial treatments? (Injectibles/Laser/chemical peels/waxing/facials)___________________

Please circle if you have any of the following conditions –

Heart Disease Excessive Bleeding High Blood Pressure Hepatitis Skin Cancer Liver Disease

Lupus Auto-Immune Disorders Diabetes Neuromuscular Disease Cold Sores/Fever Blisters

Lidocaine allergy/sensitivity

Pregnant? Y N Breastfeeding? Y N

The above information is true and accurate to the best of my knowledge.
____

_________________________________ ____________________

Client Signature **Date**