Medical History Form

Name: _____ DOB_____

Email Address_____ Cell/Phone Number _____

Home Address (street, city, state, zip) _____

_____

Are you currently under the care of a physician for any reason? YES / NO

If yes, please explain _____

Please list medications you are currently taking including Retin A, Glycolic Acid, and/or Lash Growth Serum: _____

List any drug, makeup, skin, or food allergies (i.e. soaps, or cleansing creams) _____

_____

Have you recently undergone a skin peel? YES / NO If yes, when? _____

Have you had a COVID vaccine within the past 30 days? YES / No

Do you have or have you had any of the following conditions? YES / NO; CIRCLE all that apply:

Epilepsy	High/Low Blood Pressure	Diabetes	Cold Sores/ Fever Blisters	Eye Surgery
Dry Eyes	HIV	Hepatitis	Alopecia	Trichotillomania
Artificial Heart Valve	Cancer	Thyroid Disturbances	Botox/Fillers	Scar Easily
Bruise Easily	Hemophilia	Fainting/Dizziness	Healing Problems	Bleed Easily
Hypertrophic or Keloid Scars	Prolonged Bleeding	Circulatory Problems	Sensitivity to cosmetics	Glaucoma

Are you allergic to any of the following: petroleum jelly, lidocaine, benzocaine, tetracaine, baby wipes, saline, epinephrine? YES / NO - List: _____

Emergency Contact (name/number): _____

Client Signature: _____ Date: _____