Confidential Medical Profile

Name:_____ Email:_____

Date of Birth:_____ Phone: _____

Address:_____

Emergency Contact Person:_____Phone:_____

To avoid unforeseen complications, please answer the following questions honestly. Do you have or previously had any of the following: (Check mark YES or No)

YES **NO** 18 Years of age or older
YES **NO** History of MRSA
YES **NO** Botox (Last treatment_____)
YES **NO** Diabetes
YES **NO** Hepatitis A B C D
YES **NO** HIV Positive
YES **NO** Forehead/Brow Lift /Facelift
YES **NO** Easy Bleeding
YES **NO**
YES **NO** Alcoholism
YES **NO** Abnormal Heart Condition
YES **NO** Taking medications including immunosuppressive, sucha as anti-inflammatory or steroids
YES **NO** Chemical or Laser Peel (Last Treatment_____)
YES **NO** Are you pregnant or nursing?
YES **NO** Brow Lash Tinting
YES **NO** Cancer (Year___)
YES **NO** History of skin diseases or remarkable skin conditions or sensitivities?
YES **NO** Oily Skin
YES **NO** Accutane or acne treatment
YES **NO** Currently taking Vitamin A or Vitamin E in any form?
YES **NO** Are you currently or have you ever undergone Chemotherapy/Radiation (How long in Remission_____)
YES **NO** Tan by booth or salon
YES **NO** Tumors/ Growth/ Cysts
YES **NO** Previous problems with tattoos or have you been advised by a physician NOT to get a tattoo?
YES **NO** Taking blood thinners such as: Aspirin, Ibuprofen, Alcohol, Coumadin etc. (currently or last 7 days)
YES **NO** Allergic reaction to any medications such as Lidocaine, Tetracaine, Epinephrine, Dermacaine, Benzyl Alcohol, Carbopol, Lecithin, Propylene Glycol, Vitamin E Acetate, etc_____
YES **NO** Allergies to metals, latex, food, topical anesthetic, etc_____
YES **NO** Do you use skin care products containing Retin-A, Glycolic Acid, or Alpha Hydroxyl?
YES **NO** Are you currently under the care of a physician?
YES **NO** Have you taken any mood altering drugs in the las 8 hours? Explain _____
YES **NO** Do you have problems with healing? Explain _____
YES **NO** Any diseases or disorders not listed_____
YES **NO** Circle all that apply: Heart conditions, allergies to makeup, keloid or scars, stroke, chest pain, shortness of breath, Alopecia, Epilepsy, Seizures, Refractive eye surgery, Glaucoma, Trichotillomania, Hepatitis, HIV, Jaundice, Kidney Disease, darkening of the skin

Please list any medications you are taking_____

Are there any other medical conditions that we should be aware of?_____

I agree that all the above information is true and accurate to the best of my knowledge

Signed_____Date_____