



## Medical History Form

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Telephone #: \_\_\_\_\_ Email: \_\_\_\_\_

Preferred method of contact?: \_\_\_\_\_ Appointment reminder?: **Y / N**

Ethnic Background: \_\_\_\_\_

Please list all known allergies: \_\_\_\_\_

Please list your primary skincare concerns: \_\_\_\_\_

Do you have any known sensitivities to skincare products/ingredients? **Y / N**

If yes, explain: \_\_\_\_\_

Are you currently under the care of your primary physician or dermatologist for any skin related problems? **Y / N**

If yes, explain: \_\_\_\_\_

Have you been on Accutane for any period of time within the last 12 months? **Y / N**

Have you experienced any of the following within the last 7-14 days?: *(circle all that apply)*

Cold/Fever	Conjunctivitis (pink eye)	Broken bones
Cold sores/Warts	Ringworm	Facial Bruising
Bacterial Infection	Undiagnosed lumps or swelling	Styes
Cuts/abrasions/broken skin	Recent scar tissue	Sunburn

Have you recently received any of the following services? If so, how long ago were they performed?

Waxing **Y / N** If yes, how long ago?: \_\_\_\_\_

Chemical Peels **Y / N** If yes, how long ago?: \_\_\_\_\_

Injections **Y / N** If yes, how long ago?: \_\_\_\_\_

Microdermabrasion **Y / N** If yes, how long ago?: \_\_\_\_\_

Permanent Makeup **Y / N** If yes, how long ago?: \_\_\_\_\_

Lash/Brown Tinting **Y / N** If yes, how long ago?: \_\_\_\_\_

Other: \_\_\_\_\_

I agree that the above information provided is accurate to the best of my knowledge. It is my responsibility to inform the aesthetician of all known allergies and conditions prior to treatment to prevent complications.

Name (printed): \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_