Client Medical History Form

Name ____

Address ____

Phone _________________________ Email ____

Birthdate ____

Emergency Contact Person ________________________ Phone ______________________________

Do you have or previously had any of the following: (Circle **YES** or **NO**)

YES NO History of MRSA

YES NO Botox (last treatment ________________________)

YES NO Diabetes

YES NO Hepatitis A, B, C, D YES NO Forehead/Brow lift

YES NO Easy Bleeding

YES NO Facelift

YES NO Alcoholism

YES NO Abnormal Heart Condition

YES NO Take medication prior to dental work

YES NO Chemical Peel (last treatment _________________)

YES NO Pregnant now – Breastfeeding now

YES NO Brow Lash Tinting

YES NO Autoimmune disorder

YES NO Oily Skin

YES NO Cancer (Year _______)

YES NO Accutane or acne treatment

YES NO Chemotherapy/ Radiation

YES NO Tan by booth or salon

YES NO Tumors/ Growth /Cysts

YES NO Difficulty numbing with dental work

YES NO Taking blood thinners such as: Aspirin, Ibuprofen, Alcohol, Coumadin, Etc.

YES NO Allergic reaction to any medications such as Lidocaine, Tetracaine, Epinephrine, Dermacaine, Benzyl Alcohol, Carbopol, Lecithin, Propylene Glycol, Vitamin E Acetate, other: _____________________

YES NO Allergies to metals, food, etc ____

YES NO Any disease or disorder not listed ____

YES NO Do you use skin care products containing Retin-A, Glycolic Acid, or Alpha Hydroxyl?

Please list any medications you are currently taking ____

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

Signature____Date _____________

Thank you for choosing Invigorate Spa!