DIVALOOK
CRISTINA MACHEDON

MEDICAL HISTORY FORM

Name_____Birthdate_____
Address_____
Phone_____Email_____
Emergency Contact Person_____Phone_____
Do you have or previously had any of the following: (Circle YES or No)

History of MRSA	YES	NO
Botox (Last Treatment_____)	YES	NO
Diabetes	YES	NO
Hepatitis A B C D	YES	NO
Brow lift	YES	NO
Easy bleeding	YES	NO
Facelift	YES	NO
Alcoholism	YES	NO
Abnormal Heart Condition	YES	NO
Take medication before 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
Difficulty numbing with dental work	YES	NO
Tumors/ Growth/ Cysts	YES	NO
Taking blood thinners such as: Aspirin, Ibuprofen, Alcohol, Coumadin, etc.	YES	NO
Allergic reaction to any medication such as Lidocaine, Tetracaine, Epinephrine, etc.	YES	NO
Allergies to metals, food, etc._____	YES	NO
Any diseases or disorders not listed_____	YES	NO
Do you use skin care products containing Retin-A, Glycolic Acid or Alpha Hydroxyl?	YES	NO

Please list any medication you are taking _____

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

Signed_____ Date_____