Infinite Browz by Rocky

Customer Medical History Form

Date: _____

Name: _____ Birth Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Email: _____

Emergency Contact Person: _____ Phone#: _____

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

YES NO History of MRSA

YES NO Diabetes

YES NO Cold Sores/ Fever Blisters ever?

YES NO Hepatitis (A,B,C,D)

YES NO Easy bleeding

YES NO Alcoholism

YES NO Abnormal Heart Condition

YES NO Take Meds before Dental work

YES NO Pregnant now/ Breast feeding now

YES NO Autoimmune Disorder

YES NO Cancer year

YES NO Chemotherapy/ Radiation

YES NO Tumors/ Growths/ Cysts

YES NO Botox

YES NO Lip fillers/ Restylane/ Juve derm

YES NO Blepharoplasty (Eyelid surgery)

YES NO Forehead/Brow lift

YES NO Face lift

YES NO Eye surgery/ injury/ Corneal abrasion

YES NO Contact Lenses now

YES NO Chemical Peel (last treatment _____)

YES NO Brow or Lash tinting

YES NO Oily Skin

YES NO Accutane or acne treatment

YES NO Tan by booth or sun

YES NO Difficulty numbing with dental work

YES NO Taking blood thinkers 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, etc. List: _____

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?

Please list medication or vitamins you're presently taking: _____

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

Signature: _____ Date: _____

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