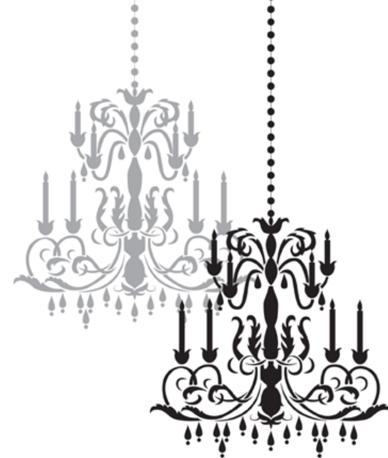

Locks & Lashes
salon

MEDICAL HISTORY

Name: ______________________________ Date of Birth: ______________________

Doctor's Name and Address: ____

Current Medications: ____

Allergies to Medications or Foods: _______________________________________

Previous Surgeries: ____

Have you used or have you had any of the following: (Please Circle)

Accutane - Laser Resurfacing - Sunburn - Retina-Burns - Liposuction - Pulsed Dye Laser - Chemical Peel - Photo-Derm - Skin Grafts - Intense Light - Glycolic Acid

IF YES PLEASE PROVIDE WHEN AND ON WHICH AREAS:

____

Do you have or have you had any of the following:

Condition	Yes	No
Bleeding Disorder	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Cold Sores	☐ Yes	☐ No
Dermatitis/Eczema	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Heart Condition	☐ Yes	☐ No
Hemophilia	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No
HIV	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
Hormone Imbalance	☐ Yes	☐ No
Keloid Scars	☐ Yes	☐ No
Latex Allergy	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No
Problems with Healing	☐ Yes	☐ No
Post Menopause	☐ Yes	☐ No
Are you under the influence of alcohol or drugs?	☐ Yes	☐ No
Pregnant or Breastfeeding	☐ Yes	☐ No

I ____,

acknowledge that to the best of my knowledge, the information I provided above is true and accurate.

Signature: ______________________________________

Witness: ____

Date: _________________________