CONSULTATION FORM

PERSONAL INFORMATION

First Name ______________________ Last Name ______________________
Address ____
Phone ______________________
Email ______________________ Referred By ______________________

ALLERGIES

Do you have any allergies? (i.e. Latex)	☐ Yes	☐ No	If yes, please specify: ______________
Are you allergic to anesthetics?	☐ Yes	☐ No	If yes, please specify: ______________
Are you allergic to antibiotics?	☐ Yes	☐ No	If yes, please specify: ______________
Have you had any eye surgeries?	☐ Yes	☐ No	If yes, please specify with date: ______________

Please specify any other allergies or concerns: ______________________________

MEDICAL HISTORY

Do you have any body tattoos?	☐ Yes	☐ No	Are you currently pregnant or breastfeeding?	☐ Yes	☐ No
Are you Diabetic?	☐ Yes	☐ No	Do you have any heart conditions?	☐ Yes	☐ No
Do you bruise easily?	☐ Yes	☐ No	Does your skin swell easily?	☐ Yes	☐ No
Have you ever had a fever blister, cold sore, or canker sore?	☐ Yes	☐ No	Have you ever tested positive for HIV or Hepatitis?	☐ Yes	☐ No
Do you have any serious medical conditions?	☐ Yes	☐ No			

Please specify any other medical conditions: ______________________________

MEDICATIONS

Are you currently taking any medications, including immunosuppressant such as an anti-inflammatory or steroid?	☐ Yes	☐ No

If yes please specify: ______________________________

Are you able to take over-the-counter antihistamine? (i.e. Benadryl)	☐ Yes	☐ No
Do you use Retinol A, Hydroyl (Glycolic) Acid preparations, Proactiv or any other anti-aging/acne products?	☐ Yes	☐ No

If yes please specify: ______________________________

Client Signature ______________ Technician Initials ______________ Date ______________