Emilia Beauty Art

Medical History

SURNAME:______________________FIRST NAME: ____________________
EMAIL:_____________________________________

D.O.B.: _______________________________ PHONE:
____
MAILING
ADDRESS:____
____
DOCTORS NAME AND NUMBER:
____
____
HOW WERE YOU REFERRED TO OUR FACILITY:
____
ALLERGIES TO ANY MEDICATIONS OR FOODS:
____
CURRENT MEDICATIONS:
____
____
PREVIOUS SURGERIES:
____
____
HAVE YOU USED OR HAVE YOU HAD ANY OF THE FOLLOWING: (please check)
Accutane __ Grafts __ Photo-derm __
Retin-A-Burns __ Glycolic Acid __ Intense Light __
Dye Laser __ Laser Resurfacing __
Chemical Peel __ Sunburn __
IF YOU CHECKED ANY, WHEN AND WHICH AREA:
____
DO YOU HAVE ANY OF THE FOLLOWING: (please check)
In Menopause __ Pregnant __ Aids __
Post Menopause __ Breast Feeding __ Cancer ___
Regular Periods __ Herpes __ Depression __
Hormone Imbalance __ Hepititis C __ Mental Illness __ Pregnant __ HIV __
MEDICAL HISTORY
DO YOU HAVE ANY OF THE FOLLOWING: (please check)
Cancer __ Contact Lenses __ Cold Sores __
High Blood Pressure __ Hemophilia __ HIV __
Heart Conditions __ Dermatitis/Eczema __ Latex Allergy __
Keloid Scars __ Pacemaker __ Hypoglycemia __ Bleeding Disorder __ Epilepsy __
I ACKNOWLEDGE THAT ALL THE ABOVE INFORMATION CONTRIBUTED BY ME IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.
SIGNATURE: ____ DATE:
____
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