Nina's TOUCH Hair & Make - Up

Client Medical History For

Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip ____

Phone _____ Studio_____

Email address (required) _____

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** Botox
- Yes/**No** Diabetes
- Yes/**No** Lip fillers/Restylane/Juve derm
- Yes/**No** Cold Sores/Fever Blister ever?
- Yes/**No** Blepharoplasty (Eyelid surgery)
- Yes/**No** Hepatitis (A,B,C,D)
- Yes/**No** Forehead/Brow lift
- Yes/**No** Easy bleeding
- Yes/**No** Face lift
- Yes/**No** Alcoholism
- Yes/**No** Eye Surgery/ Injury/ Corneal abrasion
- Yes/**No** abnormal heart condition
- Yes/**No** Contact lenses now
- Yes/**No** Take meds before dental work
- Yes/**No** Chemical treatment (Last treatment_____)
- Yes/**No** Pregnant /Breastfeeding now
- Yes/**No** Brow or 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 sun
- Yes/**No** Tumors/ Growth/ Cysts
- Yes/**No** Difficult numbing with dental work
- Yes/**No** Blood thinners such as: Aspirin, Ibuprofen, Alcohol, etc.
- Yes/No Allergies to metal, food, etc.
- Yes/No Any disease or disorder that not listed above
- Yes/**No** Allergic reaction to any medication such as Lidocaine, Tetracaine, Epinephrine, Dermacaine, Benzyl alcohol, Carbopol, Lecithin, Propylene glycol, Vitamin E acetate etc. List_____
- 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 are correct and accurate to the best of my knowledge.

Signed _____**Today's Date** _____