

Everlasting Makeup Services

Sharon Niles

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MEDICAL HISTORY

Client Name:		Address:		
Phone: (day)	(eve)	City:	State:	Zip:
Referred By:		Age:	Date of Birth:	
Procedures:		Fees: \$	Client Initial:	

Check YES or NO to all items as they apply to you on a regular or recent basis:

	YES	NO		YES	NO
Take Aspirin?	<input type="checkbox"/>	<input type="checkbox"/>	Take Vitamin E or Fish Oil?	<input type="checkbox"/>	<input type="checkbox"/>
Take Coumadin?	<input type="checkbox"/>	<input type="checkbox"/>	Wear Contact Lenses	<input type="checkbox"/>	<input type="checkbox"/>
Take Recreational Drugs?	<input type="checkbox"/>	<input type="checkbox"/>	Do you Smoke?	<input type="checkbox"/>	<input type="checkbox"/>
Take Cortizone/Steroids?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have Cosmetic Allergies?	<input type="checkbox"/>	<input type="checkbox"/>
Take Blood Thinner?	<input type="checkbox"/>	<input type="checkbox"/>	Dental Anesthetic Allergy?	<input type="checkbox"/>	<input type="checkbox"/>
Take Anti-Inflammatories?	<input type="checkbox"/>	<input type="checkbox"/>	Any Other Allergy? _____	<input type="checkbox"/>	<input type="checkbox"/>
Take Tranquilizers?	<input type="checkbox"/>	<input type="checkbox"/>	Are you Pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Take Hormones?	<input type="checkbox"/>	<input type="checkbox"/>	Are you Hemophilic?	<input type="checkbox"/>	<input type="checkbox"/>
Take Antibiotics?	<input type="checkbox"/>	<input type="checkbox"/>	Can you take BENADRYL?	<input type="checkbox"/>	<input type="checkbox"/>
Take Blood Pressure Medication?	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol within last 24 hours?	<input type="checkbox"/>	<input type="checkbox"/>
Are you Diabetic?	<input type="checkbox"/>	<input type="checkbox"/>	Laser Procedures on the Face?	<input type="checkbox"/>	<input type="checkbox"/>

Have you ever experienced any of the following:

	YES	NO		YES	NO
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>
Plastic Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Any Vision Problem	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Alopecia	<input type="checkbox"/>	<input type="checkbox"/>
Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B or C	<input type="checkbox"/>	<input type="checkbox"/>
Breast Lumps	<input type="checkbox"/>	<input type="checkbox"/>	Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>
Breast Problems	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Tested for AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Collagen Injection	<input type="checkbox"/>	<input type="checkbox"/>
Dermabrasion	<input type="checkbox"/>	<input type="checkbox"/>	Chemical Peel	<input type="checkbox"/>	<input type="checkbox"/>
Cold Sores or Fever Blisters	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>

Any other comments, conditions or allergies?...

Client/Guardian Signature

Date