Medical Health Form:

Name:____

Address:____

________________________________Postcode_________

List all medications taken in the last 6 Months

____

____

Have you taken any of the following in the last 2 days: Aspirin, Ibuprofen, Alcohol?

____

Have you received chemotherapy or radiation in the last year?___________________

Name of Doctor____

Surgery____

Allergies: Have you ever had an allergic reaction to the following?

Antibiotic creams		Latex		Nuts	
Medication		Metals		Hair Dyes	
Drugs		Foods		Lidocaine	
Paints		Crayons		Glycerine	

Other allergies____

Have you had a dental Injection?____

Are you pregnant or breast feeding?______________________________________

MRI scan due in next 3 months?____

Laser or IPL due in next 3 months?______________________________________

Have been using eyelash growth serum in the last 2 months?___________________

Do you ever give blood?____

Prior to a dental appointment are you ever given antibiotics?___________________

PTO

Please fill out the following table with a tick to indicated if any of the following relate to yourself.

Abnormal Heart Condition		**Palpitations**	
Mitral Valve Prolassed		**Heart Murmur**	
Rheumatic Fever		**Pacemaker**	
Artificial Heart Valves		**Anaemia**	
Haemophilla		**Prolonged Bleeding**	
High Blood Pressure		**Low Blood Pressure**	
Circulatory Problems		**Diabetes**	
Epilepsy		**Fainting Spells or dizziness**	
Thyroid Disturbances		**Liver Disease**	
Kidney Disease		**Glaucoma**	
Stomach Ulcers		**Tumours, Growths, Cysts**	
Cancer		**TB**	
Stroke		**HIV**	
Prosthetic's		**Systemic Lupus Erythematosus**	
Hepatitis		**Shingles**	
Seizures		**Impetigo**	
Cataracts		**Blurred Vision**	
Dry Eyes		**Do you suffer from eye infections**	
Alopecia		**Occular Herpes**	
Watery Eyes		**Contact Lenses**	
Eyelid Surgery		**Chapped Lips**	
Trichollomania		**Recent Hair Loss**	
Cold Sores (herepes complex)		**Auto Immune Conditions**	
Implants Breast		**Other Tattoos**	
Fat Injections		**Bruise or Bleed easily**	
Botox Enhancement		**Use of Sunbed**	
Dermal Fillers		**Date of last Lash Tint**	
Do you have healing problems		**Allergic to Metals**	
Do you Scar in a Raised manner		**Retin A within 6 months**	
Smoker/Vaper		**Sensitive to Cosmetics**	
Keloid Scars		**Acutance within 6 months**	
Steroids within 6 months		**Asthma**	
Scars heal darker than your skin colour		**Chemical or laser peel in last 6 months**	

Other conditions:____

Client name:________________________ Signature:____________________ Date___________

Artist:______________________________ Signature:____________________ Date___________