BROW microblading RX LLC

MEDICAL HISTORY

Name:_____ **Date of Birth:**_____

Doctor's Name & Address: **Current Medications:**

_____ _____

_____ _____

Allergies: **Previous Surgeries:**

_____ _____

_____ _____

Have you used or have you had any of the following:

Accutane **Laser Resurfacing/Hair removal** **Retin-A** **Pulsed Dye Laser**

Chemical Peel **Photo-Derm** **Skin Grafts** **Intense Pulse Light**

If YES to above when:_____

Do you have or have you had any of the following:

	Yes	No		Yes	No
Bleeding Disorder	___	___	**Heart Condition**	___	___
Cancer	___	___	**Keloid Scars**	___	___
Cold Sores	___	___	**Dermatitis/Eczema**	___	___
Diabetes	___	___	**Hepatitis**	___	___
HIV	___	___	**High Blood Pressure**	___	___
Hormone Imbalance	___	___	**Pacemaker**	___	___
Problems with healing	___	___	**Pregnant/Nursing**	___	___

I _____, acknowledge that all of the above information contributed by me is true and accurate to the best of my knowledge.

Signature:_____ **Witness:**_____ **Date:**_____