MEDICAL HISTORY QUESTIONNAIRE

First Name ______________ Last Name _____________ Date of Birth ___________ Sex ____

Address ____

Emergency Contact _______________________ Phone ________________________________

PLEASE CIRCLE ANY CONDITIONS LISTED BELOW THAT APPLY TO YOU

TB	EPILEPSY	BLOOD THINNERS	SCARRING/KELOIDING
HIV	ASTHMA	ECZEMA/PSORIASIS	GONORRHEA/ SYPHILIS
OTHER:	HEPATITIS	HEART CONDITION	MRSA/STAPH INFECTIONS
HERPES	HEMOPHILIA	PREGNANT/NURSING	ALLERGIC REACTIONS TO LATEX
DIABETES	SKIN CONDITIONS	FAINTING OR DIZZINESS	ALLERGIC REACTIONS TO ANTIBIOTICS

How long has it been since you last ate?

____

Do you have any additional allergies to items such as metals, soaps, cosmetics or alcohol?

____

Are you currently on any medications? Do you use any medications that might affect the healing of the body art you wish to receive?

____

Do you have any other medical or skin conditions that may affect the outcome of your procedure?

____

Are you currently on antibiotics? Have you ever been prescribed antibiotics prior to dental or surgical procedures?

____

Do you have any cardiac valve disease?

____

Have you ever had a herpes infection at the proposed procedure site?

____

Client Signature ______________________________________ Date _____________________