SIMPLY BLISS AESTHETICS

CLIENT HISTORY

NAME: _____ BIRTHDATE: _____/_____/_____

ADDRESS: _____ CITY: _____ ZIPCODE: _____

CELL PHONE: _____ EMAIL: _____

WHAT AREA(S) OF CONCERN DO YOU HAVE? _____

HAVE YOU EVER HAD NEUROTOXIN OR DERMAL FILLER INJECTIONS? YES / NO

LAST DATE OF NEUROTOXIN: _____/_____/_____ LAST DATE OF FILLER: _____/_____/_____

MEDICAL HISTORY

ARE YOU PREGNANT OR BREASTFEEDING? YES / NO

KNOWN CHRONIC MEDICAL CONDITIONS? Y/N AUTOIMMUNE DISEASE? Y/N SKIN CONDITIONS? Y/N

IF YES, PLEASE LIST: _____

CURRENTLY TAKING: NSAIDS (MOTRIN/ALEVE), ASPIRIN, BLOOD THINNERS, OR FISH OIL? YES / NO

HISTORY OF ANAPHYLAXIS? YES / NO, IF YES, PLEASE EXPLAIN _____

KNOWN ALLERGIES TO LATEX, ANY MEDICATION, OR TOPICAL / LOCAL ANESTHETIC? YES / NO

IF SO, PLEASE LIST: _____

HISTORY OF RAISED OR THICK SCARS, KELOIDS? YES / NO_____

PLEASE LIST ANY SURGERIES TO THE HEAD/NECK/FACE: _____

DO YOU HAVE A HISTORY OF COLD SORES OR FEVER BLISTERS? YES / NO

IF YES, LAST OUTBREAK? _____ ANTI-VIRAL MEDICATION _____

SKIN CARE HISTORY

DO YOU WEAR SUNSCREEN DAILY? YES / NO SPF_____

DO YOU USE ANY TOPICAL RETIN-A, DIFFERIN, OR ANY OTHER SIMILAR PRODUCTS? YES / NO

IF SO, HOW OFTEN DO YOU USE IT? _____ LAST USE _____

WHAT SKINCARE LINE DO YOU USE? _____

DO YOU HAVE PERMANENT MAKEUP? YES / NO (LOCATION) _____

PREFERRED PHARMACY _____ PHONE NUMBER_____

CLIENT NAME (PRINT): _____ DATE: _____/_____/_____

CLIENT SIGNATURE: _____ DATE: _____/_____/_____

NP/MD SIGNATURE: _____ DATE: _____/_____/_____