ANATOMY TATTOO
COSMETIC

CLIENT MEDICAL HISTORY FORM

NAME:____________________

DATE OF BIRTH:____________________ PHONE:____________________

EMAIL:____________________

ADDRESS:____________________

Are you pregnant or breastfeeding:

YES NO

Have you received chemotherapy or radiation in the past year:

YES NO

Are you taking blood thinners such as aspirin, ibuprofen, alcohol, coumadin etc.?

YES NO

List any medication/supplements/vitamins you have been taking in the past 6 months:

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Have you ever had an allergic reaction to any of the following:

Bee Wax Tattoo Inks	Hair Dyes	Lidocaine	Paints	Tetracaine
Vaseline Metals	Crayons	Foods	Glycerin	Epinephrine

Please Circle any of the following that apply to you:

Retin-A, Glycolic Acid, AHA's *(in the last 4 weeks)*	History of MRSA	Hemophilia	Keloid Scars
Problems	Anemia	HIV	Healing
Difficulty numbing with dental work	Sensitivity to cosmetics	Hair Loss	Scarring Easily
Fainting spells or dizziness Easily	Prolonged Bleeding	Hypertrophic scars	Bruise/Bleed
Botox/Filler injections *(in the last 4 weeks)*	Diabetes	Liver Disease	Oily Skin
	Hepatitis	Autoimmune disorders	Large Pores
Chemical/Laser Peels/Facials *(in the last 4 weeks)*	Artificial Heart Valve	Alopecia	Hormones
	Epilepsy	Tumors/Growths/Cysts	Cancer
Acne Treatment	High/Low Blood Pressure	Thyroid Disturbances	

Any diseases or disorders not on this list:____________________

I agree that all the above information is true and accurate to the best of my knowledge

Artists Name:____________________ Date:____________________

Name (print):____________________ Signature:____________________