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 _____