

Confidential Medical Profile

Sandra Centeno

Name: _____ Email: _____

Date of Birth: _____ Phone: _____

Address: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

To avoid unforeseen complications, it is very important that you answer the following questions honestly and to the best of your knowledge.

Do you have or previously had any of the following: (Check mark YES or No and explain where necessary)

- YES NO 18 Years of age or older
- YES NO History of MRSA (methicillin-resistant Staphylococcus aureus)
- YES NO Botox (Last treatment _____)
- YES NO Diabetes – (Type 1 OR Type 2)
- YES NO Herpes. _____
- YES NO Forehead/Brow Lift /Facelift/Novastring
- YES NO Easy Bleeding
- YES NO Alcoholism
- YES NO Abnormal Heart Condition (Explain: _____)
- YES NO Taking medications including immunosuppressive, such as anti-inflammatory or steroids
- YES NO Chemical or Laser Peel (Last Treatment _____)
- YES NO Are you pregnant or nursing? _____
- YES NO Brow Lash Tinting (Last Treatment _____)
- YES NO Cancer (Type: _____)
- YES NO Are you currently or have you ever undergone Chemotherapy/Radiation (How long in Remission _____)
- YES NO Tumors/ Growth/ Cysts
- YES NO History of skin diseases or remarkable skin conditions or sensitivities?
- YES NO Oily Skin
- YES NO Currently taking Accutane or acne treatment (Type: _____)
- YES NO Currently taking Vitamin A or Vitamin E in any form? (Explain: _____)
- YES NO Tan by booth or salon
- YES NO Tumors/ Growth/ Cysts
- YES NO Taking blood thinners such as: Aspirin, Ibuprofen, Alcohol, Coumadin etc. (currently or last 7 days)
- YES NO Allergic reaction to any medications such as Lidocaine, Tetracaine, Epinephrine, Dermacaine, Benzyl Alcohol, adverse reaction to dentist treatment, Carbopol, Lecithin, Propylene Glycol, Vitamin E Acetate, other: _
- YES NO Allergies to metals, latex, food, topical anesthetic, other:
- YES NO Do you use skin care products containing Retin-A, Glycolic Acid, or Alpha Hydroxyl?
- YES NO Are you currently under the care of a physician? Explain
- YES NO Have you taken any mood altering drugs in the last 8 hours? Explain
- YES NO Do you have problems with healing? Explain
- YES NO Any diseases or disorders not listed
- YES NO Circle all that apply: Heart conditions, allergies to makeup, keloid or scars, stroke, chest pain, shortness of breath,
Yes NO HIV positive
Yes NO Hepatitis =A B C D
Yes No History of allergic reaction to antibiotics
Yes No History of hemophilia or other bleeding disorder

Yes No History of medication use or is current using medication ,including being prescribed antibiotics prior to dental or surgical procedures

Yes No have cardiac valve disease. Yes No Other risk factors for Bloodborne pathogen exposure.

Alopecia, Epilepsy, Seizures, Refractive eye surgery, Glaucoma, Trichotillomania, Hepatitis, HIV, Jaundice, Kidney Disease, darkening of the skin, Rosacea, Eczema, Herpes.

Please list any medications you are taking (including Natural Supplements)

Are there any other medical conditions that we should be aware of? ___ I agree that all the above information is true and accurate to the best of my knowledge and accept that. it is my responsibility to consult with my physician and obtain the appropriate doctors note for any. contraindication that I believe may exist prior to undergoing this procedure.

Signed _____ Date _____