CLIENT MEDICAL HISTORY QUESTIONNAIRE

Name: ____ Sex: ________
Last First Middle

Date of Birth: ________________ Phone: (______) ___________ Email ___________________________

Address: ____

Emergency Contact: ____ Phone: (______) ___________

Please check any conditions listed below that apply to you.

_____ ALLERGIC TO ANTIBIOTICS
_____ ALLERGIC TO LATEX
_____ ASTHMA
_____ BLOOD THINNERS
_____ DIABETES
_____ ECZEMA/PSORIASIS
_____ HEART MURMUR
_____ HIGH CHOLESTEROL
_____ EMPHYSEMA
_____ TUBERCULOSIS
_____ LEUKEMIA
_____ STROKE
_____ HYPOTHYRODISM JAUNDICE
_____ STOMACH/ PEPTIC ULCER
_____ OTHER*

_____ EPILEPSY (SEIZURES)
_____ FAINTING OR DIZZINESS
_____ GONORRHEA/SYPHILIS
_____ HEART CONDITION
_____ HEMOPHILIA
_____ HEPATITIS
_____ PNEUMONIA
_____ COLITIS
_____ KIDNEY DISEASE
_____ ANEMIA
_____ GOITER
_____ CATARACTS
_____ HEPATITIS
_____ CANCER (*type*) ______________________________________

______ HERPES
______ HIV/ AIDS
______ MRSA/STAPH INFECTION
______PREGNANT/NURSING
______ SCARRING/KELOIDING
______ SKIN CONDITIONS
______ HIGH BLOOD PRESSURE
______ PULMONARY EMBOLISM
______ KIDNEY STONES
______ RHEUMATIC FEVER
______ ANGINA
______ CROHN'S DISEASE

Describe anything above that applies to you? ____

____

____

*If you checked other, please state the condition.

____

____

Have you ever had any of the above diseases/ infections at the proposed procedure site? Yes ___ No___

How long has it been since you last ate?

____

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

____

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

____

List all medications that you are currently taking or that you have taken in the past?

____

____

____

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

____

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

____

Please describe any exposures to bloodborne pathogens that you are aware of?

____

____

____

Do you have any cardiac valve disease?

____

Is there any other information you feel you should provide to the body art practitioner?

____

____

____

The information I have provided is complete and true to the best of my knowledge.

Print Signature of Client: ____ Date: __________________________

Signature of Client: ____ Date: __________________________