Helen Thomas
AESTHETICS
beauty therapy and permanent cosmetics

MEDICAL HEALTH FORM

Name:

Address:

Date of Birth: Occupation:

Home Phone: Work:

Mobile: E Mail

List all the medications you have been taking in the last 6 month

Have you taken any of the following in the last 2 days; Aspirin, Ibuprofen, Alcohol?

Have you received chemotherapy or radiation treatment in the last year?

Name of Doctor:

Surgery:

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

Antibiotic ointments	**Latex Rubber**	**Nuts**
Medication	**Metals**	**Hair dyes**
Drugs	**Foods**	**Lidocaine**
Paints	**Crayons**	**Glycerine**

Anaesthetics (which ones)

Other allergies (list)

Have you had a dental injection to numb your mouth?

Are you presently pregnant or breast feeding?

MRI scan scheduled in the next 3 months

Laser or IPL scheduled in the next 3 months

Do you give blood?

Prior to dental procedures do you receive antibiotic therapy?

continued overleaf

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MEDICAL HEALTH FORM

Please fill out the following table with a tick to indicate if any of the following relate to yourself.

Abnormal Heart Condition		Palpitations	
Mitral Valve Prolapsed		Heart Murmur	
Rheumatic Fever		Pacemaker	
Artificial Heart Valves		Anaemia	
Haemophilia		Prolonged Bleeding	
High Blood Pressure		Low Blood Pressure	
Circulatory Problems		Diabetes	
Epilepsy		Fainting Spells or Dizziness	
Thyroid Disturbances		Liver Disease	
Kidney Disease		Glaucoma	
Stomach Ulcers		Tumours, Growths or Cysts	
Cancer		Tuberculosis	
Stroke		HIV	
Prosthetic Hip or Joint		Systemic Lupus Erythematosus	
Hepatitis (B&C)		Shingles	
Seizures		Impetigo	
Cataracts		Blurred Vision	
Dry Eyes		Do you suffer from eye Infections	
Alopecia		Occular Herpes	
Eczema		Watery Eyes	
Psoriasis		Contact Lenses	
Eyelid Surgery		Chapped Lips	
Trichollomania		Recent Hair Loss	
Cold Sores (herpes simplex)		Auto immune conditions	
Gore-Tex Implants/Silicone Injections		Other Tattoos	
Fat Injections		Bruise or Bleed Easily	
Botox Enhancement		Use of Sun bed	
Dermal Fillers i.e restylane		Date of last eyelash/ eyebrow tint	
Do you have Healing Problems		Chemical or laser peel within 6 months	
Do you scar in a raised manner?		Retin A within 6 months	
Do your scars heal a darker colour than the rest of your skin?		AHA preparations within last 2 weeks	
Keloid Scars		Sensitivity to Cosmetics	
Accutane within 6 months		Do you tan regularly?	
Steroids within 6 months		Asthma	

Others conditions

Client Name Signature Date

Practitioner Name Signature Date

The Gables Snow Hill Dinton Salisbury Wiltshire SP3 5HN Tel 07973 833714