MEDICAL QUESTIONNAIRE

LIP BLUSH PROCEDURE

Modern BROW

Full Name:_____Date:_____

YES NO Are you at least 18 years of age?
YES NO Are you pregnant or breastfeeding?
YES NO Have you had botox in the last 2-3 weeks?
YES NO Have you had any chemical peel or laser treatments in the last 6 weeks?
YES NO Have you undergone chemotherapy or radiation therapy in the last year?

Please list any medications you have taken in the last 6 months:

_____

_____

Check any of the following that you have:

- ☐ Accutane or Acne Treatment
- ☐ Autoimmune Disorder
- ☐ Asthma
- ☐ Botox
- ☐ Cancer
- ☐ Cardiac Value Disease
- ☐ Cold Sores
- ☐ Diabetes
- ☐ Estrogen Therapy
- ☐ Epilepsy
- ☐ Forehead/Brow Lift
- ☐ Hepatitis A B C
- ☐ Hemophilia or Other Bleeding Disorders
- ☐ Herpes at Proposed Procedure Site
- ☐ HIV/AIDS
- ☐ History of MRSA / Staph Infections
- ☐ Keloid Scarring
- ☐ Oily Skin / Sensitive Skin
- ☐ Required to Take Antibiotics Before Dental or Medical Procedures
- ☐ Taking Blood Thinners such as: Aspirin, Ibuprofen, Alcohol, Coumadin, etc.
- ☐ Tan by Booth or Salon
- ☐ Tuberculosis
- ☐ Tumors/Growths/Cysts

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

- ☐ Antibiotics
- ☐ Latex
- ☐ Lidocaine
- ☐ Tetracaine
- ☐ Epinephrine
- ☐ Dermacaine
- ☐ Benzl Alcohol
- ☐ Carbopol
- ☐ Lecithin
- ☐ Propylene Glycol
- ☐ Vitamin E Acetate

YES NO I consent to having my before and after photos taken for marketing purposes.
(social media, website, advertising, etc.)

By signing here, I certify that I am at least 18 years of age and acknowledge that the above information is true and correct to the best of my knowledge:

Signature:_____