MEDICAL HISTORY QUESTIONNAIRE (Sample)

Name:_____
Last First Middle

Date of Birth: _____ Sex: _____

Address: _____

Emergency Contact: _(_____)_____ Phone: (_____)_____

Please check any conditions listed below that apply to you.

	Diabetes		Hemophilia		T.B.		Asthma
	Epilepsy		Blood Thinners		Eczema/ Psoriasis		Allergic reaction to latex
	Fainting or Dizziness		Herpes		Scarring/ Keloiding		Allergic reactions to antibiotics
	Heart Condition		Pregnancy/Nursing		Skin Conditions		Others

How long has it been since you last ate?

_____

Do you have any allergies?

_____

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?

_____

_____

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

_____

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.

Signature of Client: _____ Date: _____