LAURA McELROY
BEAUTY

401 E. 8th St. #224 (8th & RR) • Sioux Falls, South Dakota 57103 • (605) 370-1577 • www.lauramcelroybeauty.com

Today's Date _____/_____/_____

Name _____ Date of Birth _____/_____/_____ Email: _____

Ethnic Background, please include all nationalities _____

Address _____Apt. # _____City:_____

State _____ Zip _____ Home Phone (_____)_____ Cell (____)_____

Occupation: _____ If we call you at home, do you want confidentiality? No Yes

May we call you at work? No Yes If Yes, my work number is (_____)_____

Emergency Contact, Name _____ Phone (_____)_____Relationship_____

Who may we thank for referring you? _____

Procedure(s) desired: Brows Eyeliner Lips Camouflage Areola Complex Correction

List all medications you are presently taking

Name of drug	Mg. or mcg.	How many ea. day	Why it was prescribed to you

List all medications you took in the last six months that you are no longer taking:

Name of drug	Mg. or mcg.	How many ea. day	Why it was prescribed to you

Practitioner Signature _____ **Date** _____/_____/_____

GENERAL MEDICAL ClientName: _____

Do you have? (check all that apply)

Fever Blisters/Cold Sores (Ever, even one time)

Glaucoma or other eye disease/disorder

Grave's Disease

Heart Disease

Shingles History/ Recent Shingles Shot

Mitral Valve Prolapse

Valve Implants

Pacemaker

Stents

Diabetes requiring insulin

Problems with healing

Keloids

Seizures

Dermatological Disorder
If so, what? _____

Active or in Flare-ups? _____

Hemophilia or Clotting Disorder

Autoimmune Disorder

Pre-existing nerve damage

Tattoos: Colors you are sun sensitive to:

_____

Trichotillomania (pulling of hair, brows, lashes)

Alopecia Totalis or Areata

Allergies
List: _____

Are you? (check all that apply)

Pregnant
Planning cosmetic surgery
If so, what & when? _____
Currently under the care of a physician
Describe: _____

Do you practice outdoor activities? Circle all that apply

Tennis	Swimming
Golf	Skiing
Gardening	Walking
Boating	Other

Do you use? (check all that apply)

Accutane (currently or within the past year)

Antibiotics prior to dental procedures

Steroids

Retin-A, Glycolic Acid, Vitamin C or other Exfoliants

Tanning Beds

Eyebrow Tinting

Eyelash Tinting

Latisse

Botox When_____

Chemical Peels When_____

Chemotherapy or Prophylactic dose of Chemotherapy

Blood Thinners

Have you had? (check all that apply)

Fever Blisters/Cold Sores (Ever, even one time)

Eye Infections (Are you prone to them)

Vision Correction Procedure (Lasik, RK) within the past 3 months

Heart Attack - When? _____

Joint Replacement, Organ Transplant

Eye Trauma

Seizures

Fainting Spells

Hepatitis - What Type: _____

Hepatitis Test - When? _____

Fat Transfer Injections - If yes, where? _____

Gore-Tex Implants - If yes, where? _____

Aesthetic or Cosmetic Procedures
If yes, where? _____

Laser Treatments

What type & why? _____

Physician's Name:_____
Address: _____
Phone: _____
Specialty: _____

Signature of Practitioner _____ Date _____/____/_____