LAURA McELROY
BEAUTY

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CLIENT HEALTH AND MEDICAL INFORMATION

NAME_____Date of Birth:_____

ADDRESS_____

PHONE (Day)_____ Night_____

May Laura McElroy Beauty, LLC contact you at these numbers if necessary? Yes No

PROCEDURES DESIRED:
Eyeliner Eyebrows Lipline Full Lip Color Areola(s)
Beauty Mark Skin Repigmentation Other_____
If you selected "other" please explain:_____

Have you **ever** had a cold sore? Yes No

If YES, you **must** contact your physician for a prescription of ZOVIRAX capsules, an antibiotic which prevents cold sores. I have read the above information regarding ZOVIRAX and understand its **use is mandatory** if I desire lipline or full lip color procedures**.** **Client Initials _____.**

Are you currently under the care of a physician? Yes No

If so, why?_____

Physician's name:_____

Do you take antibiotics when going to the dentist? Yes No If Yes, Why?_____

Do you suffer from any of the following (please circle all that apply):

Allergies Moles or freckles at site of tattoo Hepatitis
Heart Problems Hemophilia Diabetes Skin Problems Scarring (Keloids)
Eye Problems Epilepsy Other: Please explain:_____

Are you presently taking any medication which thins the blood? Yes No

Are you taking any medications? Yes No If yes, explain: _____

Are you pregnant or nursing? Yes No

Do you wear contact lenses? Yes No

I understand that if I fail to cancel my appointment within 24 hours, there will be a charge of $100

All information contained herein, is truthful and accurate. I have fully and truthfully provided all health and medical related information to Laura McElroy Beauty, LLC.

_____ _____ _____

Printed Name Signature Date