CLIENT RECORDS

NAME:_____**DATE:** _____

ADDRESS: _____

PHONE NUMBER: _____**EMAIL**:_____

*Apply a check to the type of body art being performed**:***

TATTOO____ **PERMANENT COSMETICS**____ **BRANDING**____ **PIERCING**____

DATE OF BIRTH	**PROCEDURE SITE OF BODY ART**	**NAME AND REGISTRATION # OF PRACTITIONER**

COPY OR DESCRIPTION OF PROCEDURE

Type of identification provided:

ID of Client	**ID of Parent or Guardian (*Applicable only to underage body piercing)***

MEDICAL HISTORY QUESTIONNAIRE

Name: _____
Last First Middle

Emergency Contact:_____Phone: (_____)

Please circle any conditions listed below that apply to you.

TB	EPILEPSY	BLOOD THINNERS	SCARRING/KELOIDING
HIV	ASTHMA	ECZEMA/PSORIASIS	GONORRHEA/SYPHILIS
	HEPATITIS	HEART CONDITION	MRSA/STAPH INFECTIONS
HERPES	HEMOPHILIA/OTHER BLEEDING DISORDER	PREGNANT/NURSING	ALLERGIC REACTIONS TO LATEX
DIABETES	SKIN CONDITIONS	FAINTING OR DIZZINESS	ALLERGIC REACTIONS TO ANTIBIOTICS

How long has it been since you last ate?

_____

Do you have any additional allergies such as to metals, soaps, cosmetics or alcohol?

_____

Do you use any medications that might affect the healing of the body art you wish to receive?

_____

Do you have a history of herpes at the procedure site?

_____

Do you have any other medical or skin conditions that affect the outcome of your procedure?

_____

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

_____

Do you have any cardiac valve disease?

_____

Is there any information you feel you should provide to the body art practitioner?

_____

Other medical conditions?

_____

The information I have provided is complete and true to the best of my knowledge.

Signature of Client:_____Date:_____

Signature of Practitioner:_____Date:_____