Injected Artistry, LLC
Health History

Name: _____ Today's date: _____/_____/_____

Address: _____ Phone #:_____

Date of Birth: _____ Age: _____ Emergency Contact:_____

Who can we thank for the referral: _____

Medical History:

Are you currently under the care of a Physician, Cardiologist (Heart), Oncologist (Cancer) or Kidney Doctor (Dialysis)?

☐ Yes ☐ No If yes, Please explain: _____

Do any of the following apply: **If none, check here** ☐

☐ Cancer	☐ Seizure disorder	☐ Diabetes	☐ On Blood Thinners
☐ Pacemaker	☐ Hepatitis or Liver disease	☐ Arthritis	☐ Pregnant
☐ HIV/AIDS	☐ Herpes/Cold sores/Fever Blisters	☐ Keloid Scarring	☐ Breast Feeding
☐ Asthma	☐ Taking Hormone Replacement	☐ Depression	☐ High Blood pressure
☐ Bleeding disorder; clotting or excessive bleeding			

Do you have any Allergies? ☐ Yes ☐ No If yes, please list: _____

Have you ever had a reaction to any of the following? **If none, check here** ☐

☐ Food	☐ Animal Protein	☐ Herbal Supplements	☐ Aspirin
☐ Lidocaine	☐ NSAIDS	☐ Normal Saline	☐ Lactated Ringers
☐ Zofran	☐ Toradol	☐ Vitamin B-Complex	☐ Folic Acid
☐ Glutathione	☐ Vitamin C	☐ Biotin	☐ Amino Acids
☐ NAD+			

If Yes, Please specify: _____

Surgical History within the past year:_____

Are you taking any medications (including over-the-counter or herbal supplements) ☐ Yes ☐ No
If yes, Please list:_____

Any recreational Drugs: ☐ Yes ☐ No If Yes, Please list: _____
_____

I certify that the preceding medical, surgical and personal health history statements are true and correct. I am aware that it is my responsibility to inform the Nurse of ANY and ALL health conditions and current medications so they can treat me with a full understanding of contraindications. This is essential for the Nurse to execute the appropriate treatment. I also understand that it is my responsibility to keep my health history form updated at future visits and inform the Nurse treating me at time of service of ANY and ALL changes to my medical condition.

Signature: _____ Date: _____