

LAURA McELROY BEAUTY L.L.C.

Waxing • Makeup • Lash & Brow
www.lauramcelroybeauty.com (605) 370-1577

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** _____/_____/_____

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

Golf

Gardening

Boating

Swimming

Skiing

Walking

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 ____ / ____ / ____