Caddell's Laser and Electrolysis Clinic

Confidential Medical History - Tattoo Consultation

Last Name:_____First Name:_____MI:____

Address:_____

City:_____State:_____Zip:_____DOB:_____

Home Phone:_____May we leave a message at home? Yes/No

Work Phone:_____May we leave a message at work? Yes/No

Cell Phone:_____May we leave a message on cell? Yes/No

Email:_____May we put you on our mailing list? Yes/No

How did you hear about us?_____

MEDICAL HISTORY

CIRCLE ANY MEDICATIONS OR PROBLEMS YOU HAVE FROM THE LIST BELOW:

Antibiotics	Blood Disease	High Blood Pressure	Pacemaker	HIV
Accutane	Blood Thinners	Diuretics	Vascular Disease	Multiple Sclerosis
Acne	Canker Sores	Eczema	Keloid Scars	Immunosuppression
Aspirin	Cold Sores	Latex Allergies	Leukemia	Cancer/Skin Cancer
Birth Control	Anemia	Heart Conditions	Metal Pins	Skin Infection
Psoriasis	Collagen Vascular Disease	Hepatitis	Moles	Diabetes

List any Present Illness: _____

_____

List any Chronic Disease:_____

Have you experienced post inflammatory hyper pigmentation (brown pigmentation in the skin)? Yes/No

Please List your Present Medications (including any herbal medication(s)):_____

_____

_____

Please list any allergies (to medications or materials):_____

Are you on blood thinners? Yes/No

I acknowledge the above medical history is thorough, correct and accurate to the best of my knowledge.

Signature:_____Date: _____

Printed Name:_____

How old is your tattoo?	Is scar tissue present? Yes/No Initials:
Is this a cover or total removal?	

Do you have a tattoo under the one you want removed?