# Microneedling Intake

Are you pregnant? YES NO

Please list any medications you are taking: ____________________________________

______________________________________________________________________________

Do you have any allergies: ______________________________________________________

Have you or have you ever used Accutane Retinol Hydroquinone

When? __________________________________________________________________________

Do you have any of the following?

| | | | | |
|---|---|---|---|---|
| Acne | YES | NO | | |
| Blood Pressure | HIGH | LOW | NORMAL | |
| Cancer | YES | NO | | |
| Claustrophobic | YES | NO | | |
| Diabetes | YES | NO | | |
| Eczema | YES | NO | | Where_________________________ |
| Epilepsy | YES | NO | | |
| Headaches | YES | NO | | How often ____________________ |
| Hepatitis | YES | NO | | |
| HIV/AIDS | YES | NO | | |
| Infections | YES | NO | | |
| Lupus | YES | NO | | |
| Menopausal | YES | NO | | |
| Metal Implants | YES | NO | | Where_________________________ |
| Pacemaker | YES | NO | | |
| Phlebitis | YES | NO | | |
| Varicose Veins | YES | NO | | |
| Do you smoke? | YES | NO | | How often?_____________________ |
| Do you wear contact lenses? | YES | NO | | |

I understand and am willing to comply with all pre and post care instructions. This procedure has been explained to me and my questions regarding the treatment, its complications and risks have been answered. I understand the procedure and accept the risks, and request that this procedure be performed on me.

Client signature: ________________________________________ Date: _______________