Health Questionnaire

Client: _____

DOB: _____

Please answer each question truthfully:

- **Pregnant or breastfeeding?**
  - ☐ Yes
  - ☐ No

Allergies (if any): _____

Current medications (if any): _____

- **Bleeding disorder?**
  - ☐ Yes
  - ☐ No
- **Diabetes?**
  - ☐ Yes
  - ☐ No
- **Heart condition?**
  - ☐ Yes
  - ☐ No
- **Skin conditions?**
  - ☐ Yes
  - ☐ No

  If yes, describe: _____
- **Immune system issues?**
  - ☐ Yes
  - ☐ No

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- **Recent surgery?**
  - ☐ Yes
  - ☐ No

  If yes, provide details: _____

Other notes: _____

☐ I certify that I have answered the above questions truthfully and to the best of my knowledge.

Client Signature: _____ Date: _____

Artist/Staff Signature: _____ Date: _____

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