NEWPORT
TATTOO REMOVAL

Patient Intake Form

Client Information and Medical History

In order to provide you with the most appropriate treatment, we need you to complete the following questionnaire. All information is strictly confidential.

Client Name _____ **Today's Date** _____

Date of Birth _____ **Age** _____ **Occupation** _____

Home Address _____ **City** _____ **State** _____

Zip Code _____ **Cell Phone** _____ **Home Phone** _____

E-mail address: _____

Emergency Contact Name and Phone _____

How were you referred to us? _____

Do you regularly sun bathe or use tanning salons? How often? _____

Are you currently under the care of a physician? ☐ Yes ☐ No If yes, for what: _____

Do you have any of the following medical conditions? (Please check all that apply)
☐ Cancer ☐ Diabetes ☐ High blood pressure ☐ Herpes ☐ Arthritis ☐ Frequent cold sores
☐ HIV/AIDS ☐ Keloid scarring ☐ Seizure disorder ☐ Skin disease/Skin lesions ☐ Hepatitis
☐ Hormone imbalance ☐ Thyroid imbalance ☐ Blood clotting abnormalities ☐ Any active infection

Additional health problems or medical conditions? Please list: _____

_____

Have you ever had an allergic reaction? (List all that you have had and describe the reaction you experienced)

_____

What oral or topical medications are you presently taking? (It is required that you list all of them):

_____

Photographic Consent:
I give consent to be photographed for the purpose of medical records ☐ Yes ☐ No
I give consent to be anonymously photographed for marketing and/or publication ☐ Yes ☐ No

For our female clients:
Are you pregnant or trying to become pregnant? ☐ Yes ☐ No
Are you breastfeeding? ☐ Yes ☐ No
Are you using contraception? ☐ Yes ☐ No

I certify that the preceding medical, medication and personal history statements are true and correct. I am aware that it is my responsibility to inform the doctor or other health professional of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Patient Signature _____ Date: _____