Medical History Consultation

If you are affected by any of the following disorders or treatments, please circle each one:

High or low blood pressure

Pregnant/breastfeeding

Allergies

Pacemaker

Heart Disease

Asthma

Diabetes

Epilepsy

Eczema

Dermatitis

Acne

Vertigo

Skin Cancer

HIV or AIDS

Bruise/scar easily

Contact lenses

Eye/face surgery

Botox/fillers

Facial Peels

Daily Medications

I completely understand all of the above instructions given to me by The Powder Room and understand that there are no refunds after the procedure has been completed.

I certify that the information I have given in these forms (including the client consultation and medical history) is accurate and that I do not foresee any reason why I should not proceed with this treatment. I also acknowledge that aftercare instructions will be provided and any additional information and questions can be directed to KimberlyFindlen@gmail.com .

Client Signature_____ Date_____

Practitioner Signature_____ Date_____