LINS
LUXE
LASER

HEALTH HISTORY

Are you currently taking any medications? ☐ Yes ☐ No

If yes, please specify: .....

Do you have any known allergies (latex, adhesives, etc.)? ☐ Yes ☐ No

If yes, please specify: .....

Have you ever had any adverse reactions to beauty or skincare products? ☐ Yes ☐ No

If yes, please specify: .....

Have you had any recent eye surgeries or treatments? ☐ Yes ☐ No

If yes, please specify: .....

Do you have any skin conditions (eczema, psoriasis, dermatitis, etc.)? ☐ Yes ☐ No

If yes, please specify: .....

Do you have a history of eye infections or any eye conditions (glaucoma, conjunctivitis, etc.)? ☐ Yes ☐ No

If yes, please specify: .....

Are you currently pregnant or breastfeeding? ☐ Yes ☐ No

Additional Details:

I, _____, confirm that I have provided accurate information about my medical history, medications, and previous treatments.

_____ _____

Client Signature *Date*