Body Beautiful of NY
Lash Extensions, Cosmetic Tattooing & Esthetic Day Spa

Micro-Needling Questionnaire

Check All of the Following That Apply:

Have you ever had Micro-needling done ___ Yes ___ No
If *Yes*, when was your last treatment? _____
Who did your Micro-needling treatment? _____

Are you Pregnant or Nursing? ____Yes ____No
Are you Diabetic ? ____Yes ____No
Are you Allergic to surgical grade stainless steel? ____Yes ____No
Are you Allergic to Lidocaine, Tetracaine, Epinephrine, Deracaine, Benzyl alcohol, Carbopol, Lecithin, propylene glycol, Vitamin-E acetate, etc.
Active Acne? ___Yes ___No
If yes, have you used Minacim/Claravis/Accutane(isotretinoin) within the last year?
___Yes ___No
Are you currently on antibiotics? ___ Yes ___ No
Have you had a history of MRSA/STAFF infection ___ Yes ___ No
If Yes, when?_____
Any current skin infections/conditions ___Yes ___No
Do you have any conditions such as Hepatitis, HIV, Cancer or undergoing treatment such as chemo-therapy that could affect healing?_____
Do you have a history of chronic skin condition such as Eczema/Psoriasis ___Yes ___No
Where?_____
Any History of Keloid or hypertrophic scars? ___Yes ___ No Location _____
Do you bleed or bruise easily? ___Yes ___No
History of poor wound healing ___Yes ___No
Are you on blood thinners? (Koumadin, Asprin, IB Profin, Alieve, etc.)
_____
Do you have an Auto-Immune disorder?_____
Describe _____
Do you consume Alcohol? _____ How often?_____
Current use of controlled substances- describe _____

Have you been on Antibiotics within the last 4 weeks? ___Yes ___ No
What Kind?_____, For What?_____

Are you currently on ANY Medications? _____
List For what?_____

Are you on painkiller? ____Yes ___ No If yes, why?_____

Are you currently on Birth Control? ___Yes ___No

In the Last 48 Hours…

__ Use of Sun lamp/Tanning bed/Sun tan outdoors?
Last time you tanned _____

IPL, Laser, Fraxel, etc. treatment within 28 days _____
Date of treatment _____ Where _____

Are you currently using Retin A? ___ Yes ___ No, Part of Body_____
Are you currently using Glycolic Acid, AHA, Retinol? _____
Last used?_____

Do you have a history of facial actinic (Solar) Keratosis (Thick, scaly, crusty skin, caused by the sun)?_____

Injectables such as Restylane, Juvederm or any other fillers ?_____
If Yes! Date of last treatment _____

Have you ever had Botox ? ____Yes ____No within the last 30 days _____

Have you ever had a Chemical peel ?____Yes ____No When?_____
Deep Facial peel in the last 30 days _____Yes ____No

Have you had any cosmetic surgery ___Yes ___No
Describe _____

If you are currently under a physician's car for any condition,
describe_____

List all medication, prescription and non-prescription that you have taken in the last two weeks_____

This history has been reviewed by the technician and my questions have been satisfactory answered. I have also received and reviewed a copy of the Pre-Procedure Information Sheet and the After Care Sheet. I understand them and agree to follow them.

Signature:_____ Date:_____