 **Microchanneling Screening Form**

**BOLD** **RED** items are hard contra-indication

Name: Date:

Address:

City: St: ZIP:

Home Phone: Cell Phone:

Email: Referred by:

Yes No Are you over 18 years of age?

Yes No Do you take aspirin or blood thinners regularly?

Yes No Have you had injectables in the past 30 days?

Yes No Have you taken any mood altering drugs in the past 8 hours?

Yes No Do you have a history of cold sores, herpes or fever blisters?

Yes No Are you sensitive to Latex?

Yes No Have you had a chemical or LASER peel? If so, when?

Yes No Do you have trouble healing?

Yes No **Are you currently undergoing radiation or chemotherapy?**

Yes No Are you currently using Retin-A, AHA, or other exfoliating skin care products?

Yes No Are you allergic to any metals?

Yes No Are you currently taking anti-inflammatory medications or steroids?

Yes No Are you allergic to any anesthetics, (any of the “caines”)?

Yes No Do you have a history of skin disease?

Yes No Do you have a history of skin sensitivity?

Yes No Are you currently taking vitamin A or E in any form?

Yes No **Are you pregnant or nursing?**

Yes No Are you currently being treated by a dermatologist?

Please circle any that apply to you:

|  |  |  |  |
| --- | --- | --- | --- |
| Heart Condition | Hepatitis | HIV | Cold Sores |
| Hyper Pigment | Smoker | Compromised Immunity | **Accutane in last 2 yrs** |
| **Allergic to Steel** | **Diabetes (uncontrolled)** | **Chronic Skin Disease** | **Hemophilia** |

Practitioner’s Name:

Practitioner’s Signature: