



# CITY OF HARTFORD



**EDDIE A. PEREZ**  
Mayor

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Environmental Health Division  
131 Coventry Street  
Hartford, Connecticut 06112  
Telephone: (860) 543-8816  
Fax: (860) 543-8898  
www.hartford.gov

**CARLOS RIVERA**  
Director

## HEALTH QUESTIONNAIRE

*Your Safety is our greatest concern. Please complete this history accurately.*

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Sex \_\_\_\_\_

Date of Birth \_\_\_\_\_

### MEDICAL HISTORY (Client to Complete)

Are you taking any medication? \_\_\_\_\_

If yes, please list: \_\_\_\_\_

Have you used drugs or alcohol in the past 48 hours? \_\_\_\_\_

Do you have a history of allergies? \_\_\_\_\_ Are you allergic to any drugs? \_\_\_\_\_

Do you presently have any form of skin disease? \_\_\_\_\_

Do you have any rashes or cuts? Please describe \_\_\_\_\_

Do you have a history of diseases of the blood? \_\_\_\_\_

If yes, please describe \_\_\_\_\_

Have you ever had a body arts procedure before? \_\_\_\_\_ If yes, what type? \_\_\_\_\_

Have you ever experienced a reaction from a procedure? \_\_\_\_\_

If yes, please describe \_\_\_\_\_

I certify that I have answered these questions honestly and completely, that I am in good health and Free of the influence of drugs or alcohol, and that I request this procedure to be performed of my own Free will. I understand that this procedure may be permanent or extremely difficult to reverse.

Signature of Client \_\_\_\_\_ Date \_\_\_\_\_

Signature of Legal Guardian If Minor \_\_\_\_\_ Date \_\_\_\_\_

Client	Legal Guardian
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Name on ID \_\_\_\_\_

Name on ID \_\_\_\_\_

Type of Photo ID \_\_\_\_\_

Type of Photo ID \_\_\_\_\_

Photo ID Number \_\_\_\_\_

Photo ID Number \_\_\_\_\_

Date of Expiration \_\_\_\_\_

Date of Expiration \_\_\_\_\_

Date of Birth from ID \_\_\_\_\_

Date of Birth from ID \_\_\_\_\_

Signature of Artist \_\_\_\_\_ License # \_\_\_\_\_ Phone \_\_\_\_\_