PERMANENT MAKEUP CLIENT HISTORY

Name\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street city state zip

Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred by\_ \_\_photos b \_a \_\_\_h\_\_\_\_\_\_\_

Procedure(s) desired: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Color needle used

Upper eyeliner Partial eyebrows Full eyebrows

Lower eyeliner Lip Liner Beauty Mark

ALLERGIES: Circle all that apply

Lanolin bacitracin ointment Novocain papa

Foods latex metals lidocaine other

EYES/ BROWS

Do you have contact lenses dry eyes thyroid problems alopecia makeup sensitive glaucoma blurred vision

Eyelash tinting, date of last service\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Eyebrow tinting, date of last service\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LIPS

Chapped lips cold sores and/or fever blisters

Collagen injections fat transfers gore-tex

If you have cold sores or fever blisters a

Treatment of Zovirax or Valtrex is required prior to any lip procedure. Treatment should last for 5 days. First treatment on the day before procedure.

SKIN

Do you have any other tattoos? \_\_\_\_\_\_\_\_\_\_\_

Do you use a sunlamp and/or tanning bed?\_\_\_\_\_\_\_\_

Use Retin-A or any glycolic acids? \_\_\_\_\_\_\_\_\_\_\_

Chemical peels, if yes how long ago? \_\_\_\_\_\_\_\_\_\_\_\_\_

Do you keloid or scar badly? \_\_\_\_\_\_\_\_\_\_\_\_\_

Bruise or bleed easily? \_\_\_\_\_\_\_\_\_\_\_

Do you have any healing problems? \_\_\_\_\_\_\_\_\_\_\_\_

Do you have high blood pressure? \_\_\_\_\_\_\_\_\_\_\_\_

Diabetes? \_\_\_\_\_\_\_\_\_\_\_

Do you take aspirin on a daily basis?\_\_\_\_\_\_\_\_\_\_\_\_

Do you take fish oil? \_\_\_\_\_\_\_\_\_\_\_

Mitral Valve prolapse or valve implants? \_\_\_\_\_\_\_\_\_\_\_

Heart palpitations? \_\_\_\_\_\_\_\_\_\_\_\_\_

Have you used Accutane in the last 6 months? \_\_\_\_

Are you pregnant? \_\_\_\_\_\_\_\_\_\_\_

Ever had hepatitis/HIV? \_\_\_\_\_\_\_\_\_\_\_\_

List all medications taken within the last 2 weeks \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently under a physician’s care for any condition? If so, please describe.

Physician’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**This history has been reviewed by the tech and my questions have been satisfactorily answered.**

**I have also received and reviewed a copy of the after care sheet, understand it and agree to follow it.**

**\_\_\_\_­­ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_­­­­ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­**

**Signature date**