

Client History

Name: _____ Date of Birth: __/__/__ Today's Date: __/__/__

Address: _____ Street: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Business Phone: _____

Cell Phone: _____ May we contact you at these numbers?

Email Address: _____ Referred By: _____

Ethnic Background (include all nationalities): _____

Emergency Contact: _____ Phone Number: _____

PROCEDURE(S) DESIRED: Check all of the following that apply.

- Upper Eyeliner Partial Eyebrows Lip Liner Beauty Mark
- Lower Eyeliner Full Eyebrows Full Lip Color Scar Camouflage
- Other:

ALLERGIES: Check if you have ever had an allergic reaction to any of the following and describe what happened.

- Latex Rubber Tattoo ink/pigment Novocain, Lidocaine Benzocaine, Tetracaine
- Lanolin Bacitracin Ointment Neomycin or polymyxin B Ointment
- PABA Metal(s) Foods:

Other Allergies:

Reaction:

EYE/EYEBROWS: Check all of the following that apply

- Contact Lenses Dry eyes Eye makeup sensitivities Blurred Vision Glaucoma
- Lasik/Eye Surgery Thyroid Abnormalities Alopecia Areata (local) Alopecia Universalis (total)
- Pull out lashes/eyebrow compulsively (Trichotillomania) Other Hair Loss (describe):
- Eyebrow/Lash Tinting: Date of Last Service: __/__/__ Botox: Date of Last Service: __/__/__
- Other Eye Disorders

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LIPS: Check all of the following that apply.

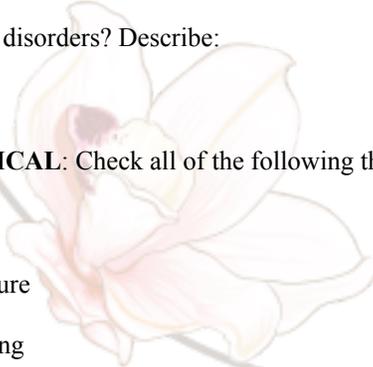
- Cold sores/fever blisters/herpes. If yes, an antiviral prescription is required prior to any lip procedure.
- Lip injections - Type: _____ Date: __/__/____
- Other lip augmentation - Type: _____ Date: __/__/____
- Teeth bleaching - Date: __/__/____

SKIN: Check all of the following that apply.

- Other tattoo locations: _____ Any Problems?: _____
- Age of tattoo _____ Currently tanned in the area being treated
- Use of sun lamp/tanning bed/sun tanning outdoors Currently using glycolic acid, AHA or Retinol?
- Currently use Retin-A - Location: _____
- Injectables such as Restylane, Juvederm or other fillers?
- Ever had a chemical peel? When: _____ Type of peel: _____
- Do you have a scar that you want camouflaged? Age of scar: _____
- Any keloid or hypertrophic scars? - Location: _____
- Do you bruise or bleed easily? Do you have healing problems?
- Other active skin disorders? Describe: _____

GENERAL MEDICAL: Check all of the following that apply.

- Diabities Heart palpitations
- High blood pressure Mitral valve prolapse or valve implants
- Pregnant or nursing Hemophilia or other clotting disorders
- Taken accutane within the last 6 months
- Currently on blood thinners or anticoagulants such as Coumadin, aspirin, ibuprofen, alcohol?
- Autoimmune disorders - describe: _____
- Do you have a condition such as Hepatitis, HIV, or undergoing treatment such as chemotherapy that could affect healing?
- Seizures - describe: _____
- Current use of controlled substances - describe: _____



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Please list any planned cosmetic or other surgeries/procedures in the near future:

List all medications, prescriptions, and non-prescriptions that you have taken in the last 2 weeks:

If you are currently under a physician's care for any condition, describe:

This history has been reviewed by the technician, and my questions have been 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: __/__/__



Orchids
PERMANENT MAKEUP
STUDIO