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: __/__/____