CLIENT HISTORY

NAME: _____ DATE: _____

ADDRESS: _____

EMAIL ADDRESS: _____

HOME PHONE: _____ CELL: _____

REFERRED BY: _____

EMERGENCY CONTACT: _____ PHONE: _____

PROCEDURE(S) DESIRED:

UPPER EYELINER ____ PARTIAL EYEBROWS ____ LIP LINER ____ BEAUTY MARK ____

LOWER EYELINER ____ FULL EYEBROWS ____ FULL LIPS____ SCAR CAMOUFLAGE____

AREOLA RE-COLORING ____ OTHER_____

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

LANOLIN____ LATEX RUBBER____ BACITRACIN OINTMENT____ NOVACAIN____

NEOMYCIN OR POLYMYXIN B OINTMENT____ LIDOCIANE____ PABA____

METALS____ FOODS_____

OTHER ALLERGIES_____

REACTION_____

HISTORY: Check all that apply:

CONTACTS____ DRY EYES____ EYE MAKEUP SENSITIVITIES____

BLURRED VISION____ THYROID ABNORMALITIES____ GLAUCOMA____

ALOPECIA UNIVERSALIS (total) ____ ALOPECIA AREATA (local) ____

OTHER HAIR LOSS, DESCRIBE: _____

Pull out lashes or eyebrows compulsively (Trichotillomainia): _____

Eyebrow tinting, date of last service: _____

Other eye disorders: _____

Lips: check all the following that apply:

Cold sores, fever blisters, herpes around the mouth. If yes, a prescription for Zovirax is required prior to any lip procedure: _____

Collagen injections, locations: _____

Fat transfer injections, locations: _____

Gore-Tex implants, locations: _____

Your stress level: No stress 1 2 3 4 5 6 7 8 9 10 Extremely stressful

Skin: check all that apply:

Any other tattoo, locations: _____

Age of tattoo(s): _____ any problems: _____

____ Use of sunlamp, tanning bed, suntan outdoors.

____ Are you currently tan in the area to be treated?

____Currently use Retin A, location: _____

____Currently using glycolic acid or other AHA skin products: _____

____Have had a chemical peel. Date: _____

____Do you have a scar you want camouflaged? Age of scar: _____

____Any keloid or hypertrophic scars, location: _____

____Bruise or bleed easily

____Healing problems

____Other active dermatological disorder. Describe: _____

_____

_____

GENERAL MEDICAL: Check all that apply:

____High blood pressure

____Diabetes ____Insulin Do you follow ADA meal plan? _____

____Currently on blood thinners or anticoagulants such as aspirin, ibuprofen, Coumadin or alcohol? Please circle.

____Hemophilia or other clotting disorders

____Mitral valve prolapsed or valve implants

____Heart palpitations

____Taken Accutane within the last 6 months

____Pregnant or nursing

____Ever had Hepatitis when: _____

____Seizures Describe: _____

____Autoimmune disorders

Please list any surgeries: _____

List all medications, prescription and non-prescription, or herbs that you have taken in the last two weeks: _____
_____

Physician's name: _____ Phone: _____

This history has been reviewed by the technician and my questions have been satisfactorily answered. I have also received a copy of the Pre- procedure information sheet and the aftercare sheet. I understand them and agree to follow them.

Signature: _____ Date: _____

Note: If you are planning cosmetic or other surgery in the near future, describe: _____
_____