CLIENT HISTORY

Name:_____ Date of Birth:_____

Address:_____

Street City State Zip

Home Phone:_____ Business Phone:_____

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

Email Address:_____ Other ID: _____

Referred By:_____

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 Liner ☐ Scar Camouflage

☐ Other:_____

Allergies: Check if you have ever had an allergic reaction to any of the following:

☐ Latex Rubber ☐Tattoo Ink/pigment ☐Novavaine, Licocaine ☐Benzocaine, Tetracaine

☐ Lanolin ☐ Bacitracin Ointment ☐Neomycin or polymyxin B ointment

☐ PABA ☐ Metal(s)

☐ Foods:_____

Other Allergies:_____

Reaction:_____

Eyes/Eybrows: Check all of the following that apply:

☐Contact Lenses ☐ Alopecia Areata (local) ☐Lasik/eye surgery ☐ Blurred Vision

☐Lasik/eye surgery ☐ Eye Makeup Sensitivities ☐ Thyroid abnormalities ☐ Dry Eyes

☐Alopecia Universalis (total) ☐Pull out lashes/eyebrow compulsively (trichotillomania)

☐Other Hair Loss (describe):_____

☐Alopecia Universalis (total) ☐Pull out lashes/eyebrow compulsively (trichotillomania)

☐Eyebrow/Lash tinting Date of last service:_____ ☐Botox Date of last service:_____

Other Eye Disorders:_____

Lips: Check all of the following that apply:

☐Cold sores/fever blisters/herpes. If yes, antiiviral prescription 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.

☐ Any other tattoos: - Location:_____

Age of Tattoo:_____ Any Problems:_____

☐ Use of sunlamp/tanning bed/suntan outdoors ☐ Currently tanned in the area being treated.

☐ Currently use Retin A – Location:_____ ☐ Currently using glycolic acid, AHA or Retinol?

☐ Injectables such as Restylane, Juvederm or other fillers? _____

☐ Ever had a chemical peel? When:_____ ☐ Type of peel:_____

☐ Do you have a scar you want camouflages? 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.

☐ Diabetes ☐ Heart Palpitations

☐ High blood pressure ☐ Mitral valve prolapse or valve implants

☐ Pregnant or nursing ☐ Hemophilia or other clotting disorders

☐ Taken Acuutane within the last 6 months

☐ Currently on blood thinners or anticoagulants such as Coumadin, aspirin, ibuprofin, alcohol?_____

☐ Autoimmune disorders – describe:_____

☐ Do you have a condition such as Hepititis, HIV or undergoing treatment such as chemotherapy that could affect healing?: _____

☐ Seizures – describe: _____

☐ Current use of controlled substances – describe:_____

Please list any surgeries:_____

If you are planning cosmetic or other surgeries/procedures in the near future, describe:_____

|_____

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

|_____

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

Physician's Name:_____ City:_____ Phone:_____

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

Signature:_____Date:_____