

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 described what happened below.

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

Other allergies: _____

Reaction: _____

EYES/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 Botox
Date of last service: _____ Date of last service: _____

Other eye disorders: _____

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.

- 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 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.

- Diabetes 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: _____

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 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: _____