Permanent Makeup

CONSULTATION FORM

CLIENT INFORMATION:

Name: ______________________ Date: ______________

Date of birth: ______________ Age: ______ ☐ Female ☐ Male ☐ Non-Binary

Address: ______________________________________

City: ______________ State: ______________ Zip: ______________

Phone: ______________ Email: ______________________

Emergency Contact: ______________ Phone Number: ______________

How did you hear about us? ______________________________

Would you like to be added to our email list for news and exclusive offers? ☐ No ☐ Yes

MEDICAL HISTORY

Please mark any of the following conditions you may currently have.

- ☐ Alopecia
- ☐ Anemia
- ☐ Cancer
- ☐ Circulatory Problems
- ☐ Cold sores or fever blisters
- ☐ Diabetes
- ☐ Eczema
- ☐ Epilepsy
- ☐ Fainting spells or dizziness
- ☐ Hair Loss
- ☐ Healing problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Hypertrophic or keloid scars
- ☐ Joint Replacements
- ☐ Liver Disease
- ☐ Low Blood pressure
- ☐ Prolonged bleeding
- ☐ Sensitivity to cosmetics
- ☐ Thyroid disturbances
- ☐ Trichotillomania
- ☐ Tumors, growths, cysts
- ☐ Other ______________

Any known allergies? ☐ No ☐ Yes ______________________

List any medications you take regularly including vitamins, herbal supplements, aspirin:

____

Any recent surgery, including plastic surgery? ☐ No ☐ Yes ______________

Are you pregnant or trying to become pregnant? ☐ No ☐ Yes

Are you taking birth control? ☐ No ☐ Yes, the brand that I am using is ______________

Do you smoke or consume alcohol? ☐ No ☐ Yes

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Have you ever had a cosmetic tattoo or permanent makeup procedure before? ☐ No ☐ Yes

If yes, when was your last procedure?

____

Do you have moles/raised areas in or around the treatment area? ☐ No ☐ Yes

Do you have or have you had a piercing in treatment area? ☐ No ☐ Yes

Are you currently wearing lash extensions of any kind? ☐ No ☐ Yes

Have you experienced Botox, Restylane or Collagen injections? ☐ No ☐ Yes

If yes, please specify:

____

Do you scar easily? ☐ No ☐ Yes

Do you bruise/bleed easily? ☐ No ☐ Yes

Have you ever had an allergic reaction to any of the following:

☐ Aspirin	☐ Glycerin	☐ Latex	☐ Paints
☐ Crayons	☐ Hair Dyes	☐ Lidocaine	☐ Vaseline
☐ Food	☐ Lanolin	☐ Medication	☐ Other:
☐ Fragrance	☐ Latex	☐ Metals	____________

What are your expectations and goals for the treatment? What would you like to improve/change about the area? Consider shape, color,density, thickness...

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Any questions or concerns about the procedure?

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<u>By signing below, you agree to the following:</u>

I have completed this form truthfully and to the best of my knowledge. I agree to waive all liabilities toward my technician and the employer for any injury or damages incurred due to any falsification of my medical history

_______________________ Client Name (Printed)

_______________________ Client Name (signature)

_______________________ Date

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