

**CLIENT HISTORY**

Name: Date of Birth:

Address:

Street City State Zip

Home Phone: Business Phone:

Cell Phone: May we contact you at these numbers:

Email Address: Other ID:

Referred By:

Emergency Contact:

**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 ☐Novovaine, Lidocaine

☐ Benzocaint, Tetracaine ☐Lanolin ☐Bacitracin Ointment

☐ Neomycin or polymyxin B Ointment ☐ PABA ☐ Metals(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)

☐ 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 augmentations - Type Date:

☐ Teeth Bleaching – Date:

**SKIN: Check all the following that apply:**

**☐**Any other tattoos – Location:

Age of Tattoo: Any problems:

☐ Use of sunlamp/tanning/suntan outdoors ☐ Currently tanned in the are being treated

☐Currently use Retin A – Location:

☐Currently using glycolic Acid, AHA, or Retinol

or other filler?

☐Ever had a chemical peel? ☐ 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 ☐Pregnant or nursing ☐Mitral valve prolapse or valve implants ☐ Hemophilia ☐ Taken Accutane within the last 6 months

☐ Are you Currently on Blood thinners or anticoagulants such as Coumadin, aspirin, ibuprofin, alcohol?

☐ Autoimmune disorder- describe:

☐ Do you have a condition such Hepatitis, HIV, or undergoing treatment such a chemotherapy that could affect healing?

☐ Seizures – Describe:

☐ Current use of controlled substances:

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:

**The history of this profile has been reviewed by the technician, and my questions has been satisfactorily answered. I have also received and reviewed a copy of the Pre-Procedure Information Sheet and the Aftercare Sheet. I understand them and agree to follow them.**

Signature: Date: