Date:

Medical Consent Form

Name: _____ Phone: _____

Address: _____ Email: _____

Emergency Contact:
Name/Relationship/Phone _____

Have you taken an aspirin or blood thinners in the last 24 hrs? Yes No

Have you ever had any tattoo procedures before? Yes No

If yes, have you had any issues healing? _____

Have you had a chemical peel, laser, Botox, or facials in the last 2 weeks? Yes No

If yes, Last treatment date

Do you have any skin issues? Yes No

Are you allergic to any dyes, latex, sanitizers, etc? Yes No

If yes please list:

_____

Do you presently have or previously had any of the following:

- History of MRSA
- Diabetes
- Hepatitis(A,B,C,D)
- Chemotherapy/Radiation
- Tumors/Growths/Cysts
- Difficulty Healing
- Difficulty numbing during dental/operations
- Easy bleeding
- Autoimmune Disorder
- Abnormal heart condition
- Cancer
- Allergy to any medications such as: Lidocaine, Tetracaine, Epinephrine, Dermacaine, Benzyl alcohol, Carbopol, Lecithin, Propylene glycol, Vitamin E, Acetate, etc:

- On Accuntane or other Acne treatments
- Pregnant or nursing