Medical History Consultation

Where is your doctor's surgery: _____

Please specify any past or impending medical operations: _____

_____

_____

Please tick the following boxes which apply to you:

- ☐ High or Low Blood Pressure
- ☐ Allergies
- ☐ Pacemaker
- ☐ Heart Disease
- ☐ Asthma
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Eczema
- ☐ Dermatitis
- ☐ Acne
- ☐ Vitiligo
- ☐ Skin Cancer
- ☐ Pregnant or Breast Feeding
- ☐ Haemophilus
- ☐ Cold Sores
- ☐ HIV or Aids?
- ☐ Hepatitis
- ☐ Bruise/Scar Easily
- ☐ Contact Lenses
- ☐ Eye/Facial Surgery
- ☐ Sensitive Eyes
- ☐ Botox
- ☐ Collagen Injections
- ☐ Facial Peels
- ☐ Medication on a Regular Basis

If you have **TICKED** the box for cold sores, use your regular cold sore cream or medication five days before (if possible) &after the micropigmentation as a preventative measure.

Do you have any other medical condition not mentioned above? If yes, please specify:

_____

_____

_____

Please let your permanent make up technician know if any of your medical information changes.

Customer Initials: