LUXE BEAUTY INK LLC
PERMANENT MAKEUP

Client Details

Name:_____DOB:_____
Address_____City:_____State:_____
Email:_____

Medical History **Check all that apply**

__Undergoing Chemotherapy
__Alopecia
__Sunburn
__Use of Alpha Hydroxy Acid
__Use Acutane, Renova or Retin-A
__Skin disorders
__MRSA
__Pacemaker
__Autoimmune disorder
__Psoriasis/Eczema
__Varicose Veins
__Ultra-Sensitive Skin
__Recent Chemical Peel
__Recent scar tissue
__Hepatitis(A,B,C)
__Diabetes
__Cold sores
__Recent Surgery to area
__Recent Permanent Makeup
__Blood Thinners
__HIV / AIDS / Herpes
__Fillers/Botox Date:_____
__Seizures
__Dermatitis
__Thyroid Disorder
__High Blood Pressure

Any other conditions, please declare here:

_____

_____

_____

Do you have any allergies? ___ Yes ____ No
Latex allergy? ___ Yes ___ No
If Yes, Please list here: _____

_____

Are you currently taking any medications including blood thinners? ___Yes ___No
If Yes, Please list here:_____

_____

Are you currently pregnant or trying to get pregnant? ___Yes ___No
Breast Feeding? ___Yes ___No

Have you undergone Permanent/Semi-permanent makeup recently? ___Yes ___No
If Yes, Please state when.

_____

_____

Have you ever had any adverse reactions to any previous treatments? ___Yes ___No
If Yes, Please state what kind of reaction you had: _____

_____

Have you exfoliated or applied any products to your body in the last 24 hours? ___Yes ___No
If Yes, Please state what products you used:_____

Please list below any prescription or over the counter medication you care currently taking.

_____

Are you currently taking any of the medication/supplements listed below

___Aspirin
___Anti-depression
___medication Anti-psychotic
___medication Ginger
___Blood Thinners
___Ibuprofen/Naproxen
___Garlic
___Fish Oil
___Hormones
___Vitamin E
___Other:

_____

_____

_____

Have you had any allergic reactions to any of the following? ___Iron Oxide ___Lidocaine (Anesthetic) ___Eggs

With every treatment there are risks involved. It is important that you understand the risks prior to undergoing treatment. Ensuring you provide a full medical history can reduce these risks but even so there may be unforeseen risks that are presented. Understanding that providing Medical History is crucial to client and technician.

Certain conditions may affect how appropriate the treatment is. Please declare all relevant history as some conditions contraindicate the treatment. By signing below, I confirm that I have provided all appropriate medical history information to the best of my knowledge.

Print Name:_____SIgnature:_____Date:_____