Mojo Master
PERMANENT MAKEUP
& PARAMEDICAL RESTORATIVE TATTOO

CLIENT MEDICAL HISTORY

Name:_____ Date Of Birth: _____

Address:_____

ALLERGIES: _____

TO AVOID UNFORESEEN COMPLICATIONS, PLEASE ANSWER THE FOLLOWING QUESTIONS

Are you under 18? □yes □ no If so, guardians initials_____

ARE YOU USING A LASH / BROW BOOST SERUM? □yes □ no

Are you allergic to any metal? □yes □ no

Have you had any aspirin or blood thinners in the past week? □yes □ no

Have you ever had any semi-permanent makeup procedures before? □yes □ no

Any mood altering drugs within the last 8 hours? □ yes □ no

Are you on any immunosuppressive medications such anti-inflammatories or steroids? □yes □ no

Do you have a history of cold sores, herpes, or fever blisters? □yes □ no

Are you allergic to topical antibiotic preparations or desensitizers? □yes □ no

Are you sensitive/allergic to latex? □yes □ no

Is there any history of skin diseases or remarkable skin sensitivities? □yes □ no

Have you had a chemical peel or laser? □ yes □ no If so, when?_____

Are you currently taking any vitamins a or e in any form? □yes □ no

Do you have problems healing? □yes □ no Are you pregnant or nursing? □yes □ no

Are you currently undergoing radiation or chemotherapy? □yes □ no

Are you required to take antibiotics during dental or invasive medical procedures? □yes □ no

Are you currently using any Retin-a or alpha-hydroxy skin care products? □yes □ no

Do you wear contact lenses? (if yes i understand they must be removed during any eyeliner procedure and should not be replaced until the next day) □yes □ no

Previous problems with tattoos or has your physician advised you not to have a tattoo at this time? □yes □ no

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CLIENT MEDICAL HISTORY

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

_____

_____

PLEASE CIRCLE ANY OF THE FOLLOWING WHICH MAY PERTAIN TO YOU:

Heart Conditions	Allergies To Makeup	Accutane Treatment	Dry Eyes
Diabetes	Stroke	Chest Pains	Alopecia
Refractive Eye Surgery	Glaucoma	Trichotillomania	Keloid/Hypertrophy Scars
Epilepsy/Seizures	Shortness of Breath	Autoimmune Disorder	Cancer (Any)
Hepatitis/ Jaundice	HIV	Kidney Disease	
Tendency To Develop Fever Blisters On The Lip		Ocular Herpes	
Hyperpigmentation	Hypopigmentation	Tendency To Bleed Excessively From Minor Injuries	

List any other medical conditions or issues not addressed above:

_____

_____

Primary Physician's Name:_____ Phone Number:_____

By signing below, I acknowledge, understand and agree that:

• The staff at *Mojo Master Permanent Makeup* does not practice medicine, does not accept health insurance, and have made no representation to the contrary.

• The information provided on this form is accurate and complete to the best of my knowledge, and that *Mojo Master Permanent Makeup* is not responsible for complications or problems arising from any incorrect or omitted information.

• Some individuals will have complications related to semi-permanent makeup application. These complications are usually mild and last only a few days. However, extreme complications are always a possibility. I accept these risks and agree to hold *Mojo Master Permanent Makeup* and its employees and contractors harmless for same.

• The staff at *Mojo Master Permanent Makeup* will use the information provided above to assess my suitability for the proposed micropigmentation services.

_____

Client Signature Date