MEDICAL HISTORY & CONSENT INTAKE FORMS

Today’s Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Apt. # \_\_\_\_\_\_\_\_\_\_\_\_City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State \_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone (\_\_\_\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell (\_\_\_\_\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If we call you at home, do you want confidentiality? **No** **Yes**

May we call you at work? **No** **Yes**

If Yes, my work number is (\_\_\_\_\_\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact:

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who may we thank for referring you? *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Procedure(s) desired:

**Brows** **Eyeliner** **Lips** **Camouflage** **Areola Complex** **Correction tattoo**

Ethnic Background, please include all nationalities:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**List all medications you are presently taking**

Name of drug Mg. or mcg. How many ea. day Why it was prescribed to you?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Practitioner Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_

**GENERAL MEDICAL** Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Practitioner Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**GENERAL MEDICAL**

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have? (Circle all that apply)**

•**Fever Blisters/Cold Sores** (**Ever, even one time)**

•Glaucoma or other eye disease/disorder

•Grave’s Disease

•Heart Disease

•Shingles History/ Recent Shingles Shot

•Mitral Valve Prolapse

•Valve Implants •Pacemaker

**Do you use? (Circle all that apply)**

•Accutane **(currently or within the past year)**

•

•Antibiotics prior to dental procedures

•Steroids

•Retin-A, Glycolic Acid, Vitamin C or other Exfoliants

•Tanning Beds

•Eyebrow Tinting

•Eyelash Tinting

•Latisse

•Stents •Botox When\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

•Diabetes requiring insulin •Chemical Peels When\_\_\_\_\_\_\_\_\_\_

•Problems with healing

•Keloids

•Seizures

•Dermatological Disorder

If so, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Active or in Flare-ups? \_\_\_\_\_\_\_\_\_\_\_\_\_

•Hemophilia or Clotting Disorder

•Autoimmune Disorder

•Pre-existing nerve damage

•Tattoos: Colors you are sun sensitive to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

•Trichotillomania (pulling of hair, brows, lashes)

•Alopecia Totalis or Areata

•Allergies

List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you? (Circle all that apply)**

•Pregnant

•Planning cosmetic surgery

If so, what & when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

•Currently under the care of a physician

`````````````````````Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you practice outdoor activities? Circle all that apply.**

Tennis Swimming

Golf Skiing Gardening Walking Boating Other

•Chemotherapy or Prophylactic dose of Chemotherapy

•Blood Thinners

**Have you had? (Circle all that apply)**

•Fever Blisters/Cold Sores (Ever, even one time)

•Eye Infections (Are you prone to them)

•Vision Correction Procedure (Lasik, RK) within the past 3 months

•Heart Attack - When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

•Joint Replacement, Organ Transplant

•Eye Trauma

• Seizures

•Fainting Spells

•Hepatitis - What Type: \_\_\_\_\_\_\_\_\_\_

•Hepatitis Test - When? \_\_\_\_\_\_\_\_\_\_Fat Transfer Injections - If yes, where? \_\_\_\_\_\_\_\_\_\_

•Gore-Tex Implants - If yes, where? \_\_\_\_\_\_\_\_\_\_

•Aesthetic or Cosmetic Procedures If yes, where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

•Laser Treatments: What type & why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Specialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Practitioner: Date:



**INFORMED CONSENT TO PROCEDURE**

1. 1. Are you pregnant or nursing? **Yes [ ]** **No [ ]**
2. I absolutely understand and accept that such a procedure is a process, often requiring multiple applications of color to achieve desirable results and 100% success cannot be guaranteed. \_\_\_\_\_\_\_\_\_\_
3. I have received, reviewed, and understand the pre-procedural instructions as given to me and agree to follow them. \_\_\_\_\_\_\_\_\_\_
4. Depending on the procedure(s), which I select, I accept responsibility for determining the shape, and position of eyebrows, eyeliners, lipliner and/or full lip color. \_\_\_\_\_\_\_\_\_\_
5. I understand that the color selection and color results in all procedures are not an exact science. \_\_\_\_\_\_\_\_\_\_
6. I understand that the positioning of my procedures can be affected if I have elected or wish to elect cosmetic surgery, Botox or Restalyne and I assume this responsibility. \_\_\_\_\_\_\_\_\_\_
7. I am aware that if I am to receive an MRI after the procedure, I must tell the Radiologist that I have iron oxide permanent cosmetics. \_\_\_\_\_\_\_\_\_\_
8. 8. If I am a lens wearer, I realize that I must keep my lenses out the day of an **eyeliner procedure**. \_\_\_\_\_\_\_\_\_\_
9. I understand that this procedure will fade, and this fading can alter the original pigment color and that this determines that it is time for a touch-up visit. \_\_\_\_\_\_\_\_\_\_
10. I realize this is an elective cosmetic procedure and is not medically necessary. \_\_\_\_\_\_\_\_\_\_
11. It has been explained to me that the following possibilities may occur: Minor and temporary bleeding, bruising, redness, or other discoloration; swelling; fever blisters on the lip area following lip procedures and/or fading or loss of pigment. \_\_\_\_\_\_\_\_\_\_
12. 12. I understand that many lasers & IPL’s (Intense Pulse Lights) including those used Photo Facials, removal of lines may or will turn permanent make up dark or even black. I agree to inform my esthetician or anyone operating such that I have permanent make up. \_\_\_\_\_\_\_\_\_\_
13. I give my consent to **Embody Ink** to confer with my physicians for medical information required for the safety of my procedures. \_\_\_\_\_\_\_\_\_\_
14. 14. I agree to accompany my practitioner to the emergency room in the event they are accidentally stuck with my needle and take a blood test for their safety & disclose all test results to my practitioner. \_\_\_\_\_\_\_\_\_\_
15. 15. I am aware that if an infection occurs after I have received Permanent Cosmetics to see with my primary physician or an emergency room, ***immediately***. \_\_\_\_\_\_\_\_\_\_

**ACCEPTANCE:**

I have read and understand these risks listed above and they have been explained to me. I certify that the information in the above questionnaire is accurate, and my questions have been answered. ***\*\*Please read all questions thoroughly before signing!!***

**Signature of Client X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please read all questions carefully before signing.**