DIVINE EYES AND BROWS

MICROBLADING/COMBO BROWS

MEDICAL INTAKE FORM

Name _____ Date _____ Emergency contact _____

Address _____ City _____ State _____

Phone _____ Email _____

Please answer the questions below truthfully to the best of your abilities, this information is crucial as it tells me if you are a viable canidate for permenent makeup.

Yes **No** Have you ever had permenant makeup done before?

Yes **No** Are you currently on any blood-thinning medications? Please list if so. _____

Yes **No** Are you currently on or recently got off ***Accutane or other acne treatments?*** Please list if so. _____

Yes **No** Are you currently, or soon plan to be, pregnant or nursing?

Yes **No** Do you exercise/sweat frequently?

Yes **No** Are you currently undergoing chemotherapy?

Yes **No** Do you have any severe skin conditions such as Eczema, Pysoriasis, Alopecia etc? Please list if so. _____

Yes **No** **Allergies to things such as citrus, latex or alcohol?**

Yes **No** **Have any severe skin conditions like Eczema, Psoriasis, Alopecia etc? Please circle any that apply.**

Yes **No** **Prone to keloids or skin tags**

Yes **No** **History of MRSA**

Yes **No** **Hepatitis, HIV, Autoimmune disorder or any blood-borne illnesses/diseases such as Anemia, Lymphoma, Hemophilia etc?**

Yes **No** **Pre-exsisting or exsisting heart condition?**

Yes **No** **Diabetes or high blood pressure**

Yes **No** **Alcoholism**

Yes **No** **Haveany tumors, cysts or growths in impacted areas**

Yes **No** **Difficulty numbing during dental work**

Yes **No** **Epilepsy**

Yes **No** **Fainting episodes**

Yes **No** **Allergic to medications such as Lidocaine, Epinepherin, Tetracaine, Dermacaine, Benzol alcohol, Vitamin E, Carbapol, lecithin, Acetate, etc? Please circle any that apply.**

Yes **No** **Use any skincare products reguarly that contain Retin-A, Retinol, Glycolic Acid or Alpha Hydroxy? Please list-**

Yes **No** **Take daily supplements or vitamins? Please list-** _____

Yes **No** **Take daily medications?** _____

Yes **No** **Any other information you think I should know?** _____

The information in this form is confidential to Aubrey Pilachowski Only. By signing, you are stating that all of the information you provided is accurate and true to the best of your knowledge.

Signature _____ Date _____

DIVINE EYES AND BROWS

MICROBLADING/COMBO BROWS

CLIENT CONSULT FORM

CLIENT CONSULTATION

Please circle any of the following you have done.

- Facials
- Chemical Peels
- Laser hair removal
- Botox
- Filler
- Retinol or Retin-A
- Alpha Hydroxyl
- Accutane
- Lash extensions, tinting or perming
- Regular brow waxing or tinting
- Invasive procedures such as extractions or laser treatments?

Please circle your current brow shape.

Please circle your brow color.

Blonde

Light brown

Medium Brown

Black

Auburn

Grey

Please circle your skin type.

Oily

Dry

Combination

Normal

*Sensitive

Please circle your pore size.

Small

Large

Inbetween

Signature : _____ **Date:** _____