

Client Medical History Consent Form

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| **Name** | **Date** | **D.O.B** | **Age** |
| **Address** | **City** | **ST** | **ZIP** |
| **Employer/Occupation** | **Home Phone** | **Cell Phone** | **Work Phone** |
| **How did you find Permanent Cosmetic Solutions** | **email** |  | ID Shown: |

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| --- | --- | --- | --- | --- | --- |
| 1 |  | Abnormal Heart Condition | 27 |  | Have you had a laser treatment in the past 6 mos.? |
| 2 |  | Cold Sores/Fever Blisters | 28 |  | Have you had a chemical peel in the past 6 mos.? |
| 3 |  | Hemophilia | 29 |  | Are you allergic to latex? |
| 4 |  | High/Low Blood Pressure | 30 |  | Are you using exfoliating products…Retin-A, Glycolic? |
| 5 |  | Had a fever in the last 3 days | 31 |  | Do you have a history of skin sensitivities? |
| 6 |  | Circulatory Problems | 32 |  | Are you allergic to topical make-ups? |
| 7 |  | Epilepsy | 33 |  | Do you bruise or scar easily? |
| 8 |  | Diabetes | 34 |  | Do you have a history of hyper or hypo-pigmentation? |
| 9 |  | Fainting/Dizziness | 35 |  | Do you have a history of keloid scars? |
| 10 |  | Cataracts | 36 |  | Are you allergic to numbing products in the ‘cain’ family? |
| 11 |  | Glaucoma | 37 |  | Do you use a tanning bed, or tan regularly? |
| 12 |  | Dry Eye | 38 |  | Do you need to pre-medicate with antibiotics? |
| 13 |  | Corneal Abrasions | 39 |  | Are you using Accutane? |
| 14 |  | Eye Surgery/Injury | 40 |  | Do you have problems healing from small wounds? |
| 15 |  | Blepharoplasty (Eyelid Lift) | 41 |  | Do you have autoimmune disorders? |
| 16 |  | Visual Disturbances | 42 |  | Are you lips injected with fillers? Lip implants? |
| 17 |  | Do you wear contact lenses? | 43 |  | Do you have Botox? Most recent injections.\_\_\_\_\_\_\_\_\_ |
| 18 |  | Cancer/Tumors/Growths/Cysts/Sty | 44 |  | Are allergic to iron-oxide or nickel?  |
| 19 |  | Chemo/Radiation | 45 |  | Do you or have you had Covid-19 symptoms/When |
| 20 |  | Are you pregnant/nursing? | 46 |  | Are you anemic? |
| 21 |  | Hepatitis | 47 |  | Do you have arthritis? |
| 22 |  | Do you use tobacco products? | 48 |  | Are you taking over the counter vitamins? |
| 23 |  | Are you taking an aspirin per day? | 49 |  | Is your skin oily? |
| 24 |  | Are you taking prescription meds? | 50 |  | Have you had permanent cosmetics or tattoos? |
| 25 |  | Are you allergic to petroleum products? | 51 |  |  How long ago? |
| 26 |  | Have you had alcohol in the past 24 hours? | 52 |  | Did you have complications during the healing process? |

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\*\*\*\*\*\*\*\*\***What color are your eyes? Brown Blue Green Hazel**

**What happens when you’re in the sun? Tan Burn Easily**

 **Eyebrows: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Eyeliner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Lip Color: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Do you prefer Gold or Silver jewelry? Gold Silver Both**

**What color are your veins? Blue Blue/Green Green**

Client Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Doctor’s Name**…………………………………………. Phone……………………….