Referred By:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To avoid unforeseen complications, please answer the following questions:

Y N Are you over the age of 18? Legal guardian’s initials: \_\_\_\_\_

Y N Have you had any aspirin or blood thinning products within the last 7 days?

Y N Any mood altering drugs within the last 8 hours? (i.e. Wellbutrin, Xanax, Prozac)

Y N Do you have any history of cold sores, herpes, or fever blisters?

Y N Are you sensitive to Latex?

Y N Have you had a chemical or laser peel?

Y N Do you have problems with healing?

Y N Previous problems with tattoos or has your

physician advised you not to have a tattoo at

this time?

Y N Are you currently undergoing radiation or

chemotherapy?

**Y N** Are you currently taking any chemotherapy

medications?

Y N Are you currently using Retin-A or “Alpha Hydroxy” skin care products? (If so, avoid

use for 1 month following procedure)

Y N Do you wear contact lenses?

Y N Are you allergic to any metal? (e.g. Can only wear 14k gold) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y N Have you ever had any permanent makeup

procedures prior to this appt. When?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y N Medication, including immunosuppressive,

such as anti-inflammatory or steroids?

Y N Withdrawal from caffeine products?

Y N Are you allergic to topical antibiotic numbing

creams or desensitizers?

Y N Is there any history of skin diseases or remarkable skin sensitivities?

Y N Are you taking any vitamins?

**Y N Are you PREGNANT or NURSING?**

Y N Are you required to take antibiotics during dental or invasive medical procedures?

Y N Do you have any drug allergies? If yes, list in space provided at the end of the form.

**Y N** Are you currently taking medication for high

or low blood pressure?

**Y N Did you work out today?**

**How many times a week do you work out\_\_\_\_**

**Y N Have you consumed alcohol today?**

Do you, or have you had, any of the following:

[ ] Tuberculosis [ ] MRSA/STAFF

[ ] Heart issue/Pace Maker[ ] Bleeding Disorder

[ ] Trichotillomania **[ ]** Eczema/Dermatitis

[ ] Allergies to makeup [ ] Hepatitis/Jaundice/HIV

[ ] Accutane treatment [ ] Kidney Disease

[ ] Dry eyes [ ] Cold sores

[ ] Keloids [ ] Glaucoma [ ] Thyroid Issues/Meds [ ] Body runs hot

[ ] Diabetes (type 1) [ ] Hyper-pigmentation

[ ] Stroke/Paralysis [ ] Hypo-pigmentation

[ ] Chest pains [ ] Herpes Simplex

[ ] Shortness of breath [ ] Refractive eye surgery

[ ] Alopecia [ ] Autoimmune disorders

[ ] Epilepsy/seizures [ ] Shingles (on face)

[ ] Smoker **[ ]** Eyelid surgery

**[ ]** Cataract surgery **[ ]** Lasik surgery

**[ ]** Tear duct plugs **[ ]** Ocular Herpes

[ ] Planning on having Facial Plastic Surgery

[ ] Cancer (List below) [ ] Head Injury/Trauma

[ ] Tan Regularly [ ] Forehead/Brow Lift

[ ] Organ transplant [ ] Rosacea (on the face)

[ ] Scar/s in area to be done?

[ ] Oily/Combination-Severe Oily skin

[ ] Other Medical Conditions/Surgeries

LIST BELOW

Please explain any checked question, list any other medical conditions or allergies, and list all your medications:

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

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Client’s Signature Date