Makeup By Maddie

Luxury Beauty Services

Client History

Name:_____Date of Birth:_____Todays Date:_____

Address:_____

Contact Number:_____May we call/text you at this number? Y/N

Email:_____

Ethnic Background (all nationalities):_____

Emergency Contact Name:_____ Number:_____

Procedure(s) Desired: Circle desired.

Powder Brows	Lip Blush	Eyeliner	Lash Line Enhancement

Allergies: Circle all that apply.

Latex Rubber	Tattoo Ink/pigment	Novocain, Lidocaine	Benzocaine, Tetracaine
Lanolin	Bacitracin Ointment	Neomycin or Polymyxin B Ointment	PABA/Metals

Food Allergies:_____

Other Allergies:_____

Reaction:_____

Eyebrows/Eyes: Circle all that apply.

Contact Lenses	Dry Eyes	Eye Makeup Sensitivities	Blurred Vision	Glaucoma
Lasik/Eye Surgery	Thyroid Abnormalities	Alopecia Areata (local)	Alopecia Universalis (total)	Trichotillomania (compulsively pull out lashes)

Other Hair Loss:_____

Eyebrow/Lash Tinting Last Date of Service:_____

Other eye disorders:_____

LIPS: CIRCLE ALL THAT APPLY.

Y/N Cold sores/fever blisters/herpes. If yes, and antiviral prescription is required prior to any procedure.

Y/N Lip Injections – Type:_____ Date:_____

Y/N Other Lip Augmentation – Type:_____ Date:_____

Y/N Teeth bleaching – Date:_____

SKIN: CIRCLE ALL THAT APPLY.

Y/N Do you have any tattoos – Location:_____

Y/N Any problems with current tattoos? _____

Y/N Use of sunlamp/tanning bed/suntan outdoors?

Y/N Currently use Retin A – Location _____

Y/N Injectables (Restylane, Juvederm, or other fillers)?

Y/N Have you ever had a chemical peel? If so when was your last one?_____

Y/N Any keloid scars – Location:_____

Y/N Do you bleed or bruise easily?

Y/N Any other skin disorders? Describe:_____

GENERAL MEDICAL: CIRCLE ALL THAT APPLY.

Diabetes	Heart Palpitations	High Blood Pressure	Mitral Valve Prolapse/Valve Implants	Hemophilia or other clotting disorders
Pregnant/Nursing	Accutane in the last year	Blood thinners or anticoagulants (coumadin, Aspirin, ibuprofen, alcohol)	Autoimmune Disorders	Hepatitis, HIV, or undergoing chemotherapy/radiation

Y/N Seizures – Describe:_____

List all medications, prescriptions, and non-prescription that you have taken in the last two weeks:_____
Physicians Name:_____City:_____Phone:_____

This history has been reviewed by the technician and my questions have been satisfactorily answered. I have also received and reviewed a copy of the pre-procedure information sheet and aftercare sheet. I understand them and agree to follow them.

Signature:_____Date:_____