CLIENT HISTORY

Name: ______________________ Date of Birth: ______________________

Address: ____
Street City State Zip

Home Phone: ______________________ Business Phone: ______________________

Cell Phone: ______________________ May we contact you at these numbers? ______________

Email Address: ______________________ Other ID: ______________________

Referred by: ____

Emergency Contact: ______________________ Phone Number: ______________________

PROCEDURE(S) DESIRED: Check all of the following that apply.

- ☐ Upper eyeliner ☐ Partial eyebrows ☐ Lip liner ☐ Beauty mark
- ☐ Lower eyeliner ☐ Full eyebrows ☐ Full lip color ☐ Scar Camouflage
- ☐ Other: ____

ALLERGIES: Check if you have ever had an allergic reaction to any of the following and described what happened below.

- ☐ Latex rubber ☐ Tattoo ink/pigment ☐ Novovaine, Lidocaine ☐ Benzocaine, Tetracaine
- ☐ Lanolin ☐ Bacitracin Ointment ☐ Neomycin or polymyxin B ointment
- ☐ PABA ☐ Metal(s)
- ☐ Foods: ____

Other allergies: ____

Reaction: ____

EYES/EYEBROWS: Check all of the following that apply.

- ☐ Contact lenses ☐ Dry eyes ☐ Eye makeup sensitivities ☐ Blurred Vision
- ☐ Glaucoma ☐ Lasik /eye surgery ☐ Thyroid abnormalities ☐ Alopecia Areata (local)
- ☐ Alopecia Universalis (total) ☐ Pull out lashes/eyebrow compulsively (Trichotillomania)
- ☐ Other hair loss (describe): ____
- ☐ Eyebrow/Lash tinting
  Date of last service: ______________
- ☐ Botox
  Date of last service: ______________

Other eye disorders: ____

LIPS: Check all of the following that apply.

- ☐ Cold sores/fever blisters/herpes. If yes, an antiviral prescription is required prior to any lip procedure.
- ☐ Lip injections - Type: ______________________ Date: ______________________
- ☐ Other lip augmentation - Type: ______________________ Date: ______________________
- ☐ Teeth bleaching - Date: ______________________

SKIN: Check all of the following that apply.

- ☐ Any other tattoos - Location: ______________________________
  Age of tattoo: ____________________ Any problems: ____________________
- ☐ Use of sunlamp/tanning bed/suntan outdoors
- ☐ Currently tanned in the area being treated.
- ☐ Currently use Retin A - Location: ____________
- ☐ Currently using glycolic acid, AHA or Retinol?
- ☐ Injectables such as Restylane, Juvederm or other fillers? ______________________________
- ☐ Ever had a chemical peel? When:____________
- ☐ Type of peel:____________________
- ☐ Do you have a scar you want camouflaged? Age of Scar: ______________________________
- ☐ Any keloid or hypertrophic scars? - Location: ______________________________
- ☐ Do you bruise or bleed easily?
- ☐ Do you have healing problems?
- ☐ Other active skin disorders? Describe: ______________________________
  ____

GENERAL MEDICAL: Check all of the following that apply.

- ☐ Diabetes
- ☐ Heart Palpitations
- ☐ High blood pressure
- ☐ Mitral valve prolapse or valve implants
- ☐ Pregnant or nursing
- ☐ Hemophilia or other clotting disorders
- ☐ Taken Accutane within the last 6 months
- ☐ Currently on blood thinners or anticoagulants such as Coumadin, aspirin, ibuprofin, alcohol? ____________
- ☐ Autoimmune disorders - describe: ______________________________
- ☐ Do you have a condition such as Hepatitis, HIV or undergoing treatment such as chemotherapy that could affect healing?
  ____
- ☐ Seizures - describe: ______________________________
- ☐ Current use of controlled substances - describe: ______________________________

Please list any surgeries: ______________________________

If you are planning cosmetic or other surgeries/procedures in the near future, describe: ____________________
____

List all medications, prescription and non-prescription that you have taken in the last two weeks: ____________
____

If you are currently under a physician's care for any condition, describe: ____________________

Physician's 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 the After Care Sheet. I understand them and agree to follow them.

Signature: ______________________________ Date: ____________________