PERMANENT MAKEUP

CONSULTATION FORM

Name: ______________________________

Address: ______________________________

Home/Cell Phone: ______________ Email address: ______________

Emergency Contact
Name / Relationship / Phone: ______________/______________/______________

Are you under 18? ☐ YES ☐ NO

Have you had any aspirin or blood thinners in the past week? ☐ YES ☐ NO

Have you ever had any permanent makeup procedures before? ☐ YES ☐ NO

Have you had a chemical peel, laser, forehead / brow lift, or facial fillers ? ☐ YES ☐ NO

If so, last treatment date ______________

Do you have problems healing? ☐ YES ☐ NO

Previous problems with tattoos or has your physician advised you not to have a tattoo at this time? ☐ YES ☐ NO

Are you allergic to any foods, metal, latex, antibiotics, sanitizers? If yes. please list: ☐ YES ☐ NO

Do you presently have or previously had any of the following:

- ○ Yes ○ No - History of MRSA
- ○ Yes ○ No - Diabetes
- ○ Yes ○ No - Hepatitis (A,B,C,D)
- ○ Yes ○ No - Easy bleeding
- ○ Yes ○ No - Face lift
- ○ Yes ○ No - Alcoholism
- ○ Yes ○ No - Abnormal Heart Condition
- ○ Yes ○ No - Take meds before Dental work
- ○ Yes ○ No - Brow or Lash tinting
- ○ Yes ○ No - Autoimmune Disorder
- ○ Yes ○ No - Oily Skin
- ○ Yes ○ No - Cancer year_____
- ○ Yes ○ No - Accutane or acne treatment
- ○ Yes ○ No - Chemotherapy/ Radiation
- ○ Yes ○ No - Tan by booth or sun
- ○ Yes ○ No - Tumors/ Growths/ Cysts
- ○ Yes ○ No - Difficulty numbing with dental work
- ○ Yes ○ No - Taking blood thinnners such as: Aspirin, Ibuprofen, alcohol, Coumadin, ect. ______________
- ○ Yes ○ No - Allergic reaction to any medications such as Lidocaine, Tetracaine, Epinephrine, Dermacaine, Benzyl alcohol, Carbopol, Lecithin, Propylene glycol, Vitamin E Acetate, ect. List______________
- ○ Yes ○ No - Any diseases or disorders not
- ○ Yes ○ No - Do you use skin care products containing Retin-A, glycolic acid or alpha hydroxyl?

FEMALE CLIENTS:

Are you pregnant or trying to become pregnant ? ☐ YES ☐ NO

Are you breastfeeding ? ☐ YES ☐ NO

Are you using oral and / or hormone based contraceptives ? ☐ YES ☐ NO

PLEASE CIRCLE ANY OF THE FOLLOWING THAT MIGHT APPLY TO YOU:

☐ Botox ☐ Fillers ☐ Brow Lift ☐ Face Lift ☐ Easy Bruising ☐ Easy Bleeding ☐ Chemical Peels ☐ Facials
☐ Brow/Lash tint ☐ Brow/Lash lift ☐ Tanning ☐ Spray Tan ☐ Difficulty numbing at Dentist
☐ None of the Above