PERMANENT/SEMI-PERMANENT CLIENT INFO & MEDICAL HEALTH FORM

CLIENT NAME:	DATE OF BIRTH:
ADDRESS:	
PHONE:	EMAIL:
Referred By:	Occupation:
Primary Physician Name & Phone Number:	
Please list any medications you are currently taken and/or have taken in the past 6 months:	

DO ANY OF THE FOLLOWING CONDITIONS / SITUATIONS PERTAIN TO YOU?	**YES**	**NO**
Allergic to latex, metals, hair dye, lidocaine, paints, crayons, glycerin, cosmetics Any other known allergies? Please list:		
At the dentist, do you anesthetize easily?		
Have you received chemotherapy treatment within the past 6 months? If yes, please enter date of final treatment:		
Are you pregnant or nursing?		
Do you have an auto-immune disorder?		
Do you have a thyroid disorder?		
Do you have a heart condition? If yes, is it being treated/monitored?		
Prior to dental or surgical procedures, do you receive antibiotic therapy?		
Do you have glaucoma or other eye disease, disorder or eye trauma?		
Do you wear contact lenses? If yes, please do not wear them on day of PMU eyeliner procedure		
Are you prone to eye infections?		
Do you suffer from Hepatitis, or other risk factors for blood borne pathogen exposure, or any other communicable disease?		
Do you have diabetes? If yes, is it being treated and monitored by your physician?		
Do you have epilepsy, anemia, hemophilia or other blood/bleeding disorders?		
Are you on any blood thinning medication?		
Do you bruise, swell or bleed very easily?		
Do you take aspirin on a daily basis?		
Do you drink alcohol?		
Do you have a history of herpes infection (cold sores/fever blisters)?		

Do you suffer from a medical skin condition such as Keloids or hypertrophic scarring, psoriasis, or any current open wounds or lesions?		
Are you currently on Accutane, or have you taken it within the last year?		
Do you use Retin-A, Glycolic Acid, Vitamin C or other exfoliants? If yes, please list:		
Have you had a chemical peel? If yes, list date of last treatment:		
Do you tint you eyebrows and/or eyelashes?		
Are you presently using eyelash enhancing products?		
Are you currently on steroids or anti-inflammatory medications? If yes, please list:		
Have you had Botox injections? If yes, list what are of face and most recent date of injections below:		
Do you have collagen, Restalyne, Juvederm or fat transfers injected into your lips?		
Do you have tattoos?		
Do you spend a lot of time in the sun?		
Do you spend a lot of time in a chlorinated pool?		
Do you use sunscreen regularly?		
Are you planning any cosmetic surgery in the near future?		
Have you had laser treatments? What type? When?		
Are you currently under a physician's care for any condition? If yes, please describe:		
Primary Physician's Name: Address: Phone:		
Is there anything else I need to know about your health or healing that could complicate this procedure? If yes, please list here:		

I HEREBY CERTIFY THAT ALL STATEMENTS CONTAINED WITHIN THIS DOCUMENT HAVE BEEN READ, UNDERSTOOD, AND ANSWERED ACCURATELY, AND ARE TRUE TO THE BEST OF MY KNOWLEDGE

CLIENT NAME (Printed): ____

CLIENT SIGNATURE: ______________________________ DATE: ____________

TECHNICIAN SIGNATURE: ___________________________ DATE ____________