INFO & MEDICAL HEALTH FORM

CLIENT NAME: *(please print)*	**DATE OF BIRTH:**
ADDRESS:	
PHONE:	**EMAIL:**
Referred By:	**Occupation:**

DO ANY OF THE FOLLOWING CONDITIONS / SITUATIONS APPLY TO YOU?	**YES**	**NO**
Allergic to latex, metals, hair dye, lidocaine, paints, crayons, glycerin, cosmetics? Any other known allergies? If yes, please list on back of form		
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 any of the following: Auto-immune disorder Thyroid disorder Hepatitis A, B or C HIV AIDS		
Do you have a heart condition? If yes, is it being treated/monitored?		
Do you have glaucoma or other eye disease, disorder or eye trauma, or suffer from frequent eye infections?		
Do you wear contact lenses? If yes, please do not wear them on day of PMU eyeliner procedure		
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? (including daily aspirin)		
Do you bruise, swell or bleed very easily?		
Do you drink alcohol? If yes, have you consumed more than 8oz of alcohol within the past 24 hours? Y / N		
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 your brows and/or lashes, or currently use eyelash enhancing products? *(such as LaTisse)* Please circle any and all that apply		
Are you currently on steroids or anti-inflammatory medications? If yes, please list:		
Have you had Botox injections? If yes, list area of face and most recent date of injections:		
Do you have collagen, Restalyne, Juvederm or fat transfers injected into your lips?		
Do you have tattoos? If yes, did you heal normally after the procedure? Y / N If no, please describe on back of form.		
Do you spend a lot of time in the sun and/or a chlorinated pool? (If yes, please circle one or both)		
Do you use sunscreen regularly?		
Are you planning any cosmetic surgery in the near future? If yes, please list what and approximately when you intend to do so on back of form.		
Have you had or plan to have laser treatments? What type? When?		
Are you currently under a physician's care for any condition? If yes, please describe on back of form.		
Primary Physician's Name: Phone:		
Please list any medications you have taken within the past 6 months:		
Is there anything else I need to know about your health or healing that could complicate this procedure? If yes, please list on back of form:		

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 SIGNATURE:: _____ DATE: _____

TECHNICIAN SIGNATURE: _____ DATE: _____