MEDICAL HISTORY FORM
Permanent Makeup (Cosmetic Tattoo) Procedures

Name: **DOB:** **Date:**

Address:

PostCode: **Bus. Ph:** **Home Ph:**

Mobile: **Email:**

Subject to my suitability, I wish to have the following Permanent Makeup procedures:

Eyebrows☐ Lip Line☐ Eye Shadow☐ Upper Eyeliner☐ Lip Line & Blend☐

Beauty Spot☐ Lower Eyeliner☐ Full Lip Colour☐ _____☐

Further Comments Regarding Procedures:_____

ALLERGIES: Have you ever had a reaction following exposure to any of the following?

			Details
PABA (Sunscreen)	YES	NO	
Lanolin	YES	NO	
Novocain	YES	NO	
Lidocaine	YES	NO	
Latex Protein	YES	NO	
Metals	YES	NO	
Foods	YES	NO	
Other	YES	NO	

GENERAL MEDICAL: Do you suffer from any of the following (or have you in the past)?

Diabetes	YES	NO	
Epilepsy	YES	NO	
High Blood Pressure	YES	NO	
Haemophilia or other clotting disorder	YES	NO	
AIDS	YES	NO	
Hepatitis	YES	NO	Type/When?
Mitral valve prolapse or implant	YES	NO	
Heart palpitations	YES	NO	
Rheumatic fever	YES	NO	
Autoimmune disorders	YES	NO	
Cancer	YES	NO	Type?

Client Name:_____Signature:_____Date:_____

Practitioner:_____Signature:_____Date:_____

GENERAL MEDICAL: Do any of the following apply to you (now or in the past)?

			Details
Pacemaker	YES	NO	
Pregnant or lactating	YES	NO	
Smoking	YES	NO	How many?
Alcohol consumption	YES	NO	What/How many?
Currently taking blood thinners or anti-coagulants (such as Aspirin, Ibuprofen, Coumadin)?	YES	NO	
Taken Accutane in the last 6 months?	YES	NO	
Currently under medical supervision for any disorders?	YES	NO	

SKIN: Do any of the following apply to you (now or in the past)?

Psoriasis, Eczema, Dermatitis or similar	YES	NO	
Slow to heal	YES	NO	
Tan easily	YES	NO	
Burn easily	YES	NO	
Use a sunlamp, solarium or sun bake	YES	NO	
Currently tanned in the area to be treated	YES	NO	
Regularly swim in pool	YES	NO	
Any keloid or hypertrophic scarring	YES	NO	Where?
Using glycolic acid or other AHA skin products	YES	NO	List:
Laser resurfacing	YES	NO	When?
Chemical peel	YES	NO	Type?
TATTOOS (including permanent makeup procedures)	YES	NO	Locations/when/any complications?

Client Name:_____Signature:_____Date:_____

Practitioner:_____Signature:_____Date:_____

COMPLETE FOR EYE &/OR BROW TREATMENT: Do any of the following apply to you (now or in the past)?

			Details
Glaucoma	YES	NO	
Alopecia (hair loss)	YES	NO	
Trichotillomania (compulsively pull out eyelashes)	YES	NO	
Other hair loss	YES	NO	Describe:
Cataracts	YES	NO	
Blurred vision	YES	NO	
Dry or sensitive eyes	YES	NO	
Allergy to cosmetics or makeup	YES	NO	
Thyroid abnormalities	YES	NO	Describe:
Contact lenses	YES	NO	

COMPLETE FOR LIP PROCEDURE: Do any of the following apply to you (now or in the past)?

Dry chapped lips	YES	NO	
Herpes (cold sores) around the mouth	YES	NO	Last outbreak?
Fever blisters or mouth ulcers	YES	NO	
Collagen injections	YES	NO	Location/when?
Gortex implants	YES	NO	Location/when?
Fat transfer injections	YES	NO	Location/when?

OTHER RELEVANT DETAILS: Please provide any other details considered relevant.

This three page document is a true and accurate statement of my medical history, past and present. I am aware that failure to disclose information pertinent to my treatment could have serious health ramifications. I am also aware that failure to disclose information pertinent to my treatment could have a direct bearing on treatment outcome.

Client Name:_____Signature:_____Date:_____

Practitioner:_____Signature:_____Date:_____