Name______________________________ Birth date____________Age___

Address__________________________City__________State________Zip_____

Phone Home_____________ Cell______________ Email address________________

Referred by_________________________

YES / NO Are you pregnant or nursing?	YES / NO Do you consume aspirin daily?
YES / NO Have you had any alcohol in the last 24 hours?	YES / NO Are you under treatment for depression?
YES / NO Have you ever had cold sores or fever blisters?	YES / NO Do you have any type of herpes?
YES / NO Do you have any allergies to latex?	YES / NO Are you sensitive to petroleum based products?
YES / NO Have you had a laser or chemical peel within 6 months?	YES / NO Do you have botox injections?
YES / NO Have you ever had any permanent cosmetics or tattoos applied?	YES / NO If you have permanent cosmetics or tattoos did you have any problems with healing after they were applied?
YES / NO Does your skin show signs of bruising for no obvious reason?	YES / NO Are you undergoing radiation or chemo-therapy treatment?
YES / NO Do you routinely use Retin-A, glycolic, or other exfoliating products?	YES / NO Are you now, or have you ever been on the acne treatment Accutane?
YES / NO Do you wear contact lenses?	YES / NO Are you wearing a pacemaker?
YES / NO Are you allergic or sensitive to any metals?	YES / NO Do you take prescription drugs?
YES / NO Do you have any problems healing from small wounds?	YES / NO Are you anemic?
YES / NO Is your skin oily?	YES / NO Do you have a history of skin sensitivities?
YES / NO Do you use tobacco? If you use tobacco you may heal slower and this affects the timing on scheduling a touch up appt. if applicable.	YES / NO Do you have any medical condition that has resulted in a medical professional requiring you to pre-medicate with an antibiotic prior to a dental or other invasive procedures?
YES / NO Do you have any heart conditions?	YES / NO Do you have any allergies to topical makeup?
YES / NO Are you diabetic? If yes, Type 1 or Type 2?	YES / NO Do you have dry eyes?
YES / NO Do you have any autoimmune disorders?	YES / NO Do you intentionally tan - Direct sun or tanning bed?
YES / NO Are you sensitive or allergic to hand creams or body lotions?	YES / NO Do you personally have any history of cancer?
YES / NO Do you have your lips injected with filler materials?	YES / NO Do you have a history of stroke or heart attack?
YES / NO Do you menstruate? If yes, next cycle date:	YES / NO To your knowledge are you allergic or resistant to over the counter level numbing products?
YES / NO Do you hyper-pigment? (Tendency to develop dark spots on the skin from wounds or sun?)	YES / NO Do you hypo-pigment? (Lack of pigment on the skin)
YES / NO Do you tend to develop keloid or hypertrophy scars?	YES / NO Are you allergic to hair dyes?
YES / NO Do you scar easily from minor skin injuries?	YES / NO Do you have glaucoma or any other eye disease?
YES / NO Do you have any seizure related conditions?	YES / NO Do you have arthritis?
YES / NO Do you have a tendency to faint or become dizzy?	YES / NO Do you have high or low blood pressure?
YES / NO Do you bleed excessively from minor cuts?	YES / NO Do you have sinus problems?
YES / NO Do you have prosthetic implants?	YES / NO Do you have any type of hepatitis?

If you answered "YES" to any question above, use the space below and the reverse side of this form to provide an explanation. Correlate your explanation to a specific question number.
A "yes" answer does not indicate you are not an acceptable candidate for permanent cosmetics. It may simply be information that is valuable to me as your technician as each person's body is unique, or it may indicate that based on any health conditions that affect healing, it would be advisable or required for you to consult with your physician before proceeding. If this form has not addressed a medical condition you have, please list it below.

Client Signature ________________________________ Date ____________________