Client Health HISTORY

INK BROW STUDIO
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Name: _____
Date of Birth: ____/___/_____
Email: _____
Ethnic Background, please include all nationalities:
_____
Address:_____ Apt# _____ City: _____
State:_____ Zip:_____ Home Phone: ( ) _____ Cell: ( ) _____
Occupation: _____ If we call you at home, do you want confidentiality?
May we call you at work? ☐ No ☐ Yes
If Yes, my work number is ( )_____
Emergency Contact: Name_____ Phone ( ) _____ Relationship _____
Who may we thank for referring you? _____
Procedure(s) desired: ☐ Brows ☐ Eyeliner ☐ Lips ☐ Camouflage ☐ Areola Complex ☐ Correction

List all medications you are **presently** taking:

Name of drug	Mg. or mcg	How many ea. day	Why it was prescribed to you

List all medications you took **in the last six months** that you are no longer taking:

Name of drug	Mg. or mcg	How many ea. day	Why it was prescribed to you

Practitioner Signature: _____Date:____/___/_____

General MEDICAL

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Do you have? (check all that apply)

- ☐ Fever Blisters/Cold Sores (Ever, even one time)
- ☐ Glaucoma or other eye disease/disorder
- ☐ Grave's Disease
- ☐ Heart Disease
- ☐ Shingles History/Recent Shingles Shot
- ☐ Mitral Valve Prolapse
- ☐ Valve Implants
- ☐ Pacemaker
- ☐ Stents
- ☐ Diabetes requiring insulin
- ☐ Problems with healing
- ☐ Keloids
- ☐ Seizures
- ☐ Bell's Palsy - Active or in Flare-ups?

  _____
- ☐ Dermatol
- ☐ Hemophilia or Clotting _____
- ☐ Pre-existing nerve damage
- ☐ Tattoos: Colors you are sun sensitive to:

  _____
- ☐ Trichotillomania (pulling of hair, brows, lashes)
- ☐ Alopecia Totalis or Areata
- ☐ Allergies: _____

Are you? (check all that apply)

- ☐ Pregnant
- ☐ Planning Cosmetic If so, what & when?

  _____
- ☐ Currently under the care of a physician Describe

  _____

Do you practice outdoor activities? Circle all that apply:

Tennis	Skiing
Golf	Walking
Gardening	Boating
Swimming	Other

Client Name:_____

Practitioner Signature: _____

Date:___/___/_____

Do you use? (check all that apply)

- ☐ Accutane (currently or within the past year)
- ☐ Antibiotics prior to dental procedures
- ☐ Steroids
- ☐ Retin-A, Glycolic Acid, Vitamin C or other Exfoliants
- ☐ Tanning Beds
- ☐ Eyebrow Tinting
- ☐ Eyelash Tinting
- ☐ Latisse
- ☐ Botox When _____
- ☐ Chemical Peels When _____
- ☐ Chemotherapy or Prophylactic dose of Chemotherapy
- ☐ Blood Thinners

Have you had? (check all that apply)

- ☐ Fever Blisters/Cold Sores (Ever, even one time)
- ☐ Eye Infections (Are you prone to them)
- ☐ Vision Correction Procedure (Lasik, RK) within the past 3 months
- ☐ Heart Attack - When? _____
- ☐ Joint Replacement, Organ Transplant
- ☐ Eye Trauma
- ☐ Seizures
- ☐ Fainting Spells
- ☐ Hepatitis - What Type: _____
- ☐ Hepatitis Test - When? _____
- ☐ Fat Transfer Injections - If yes, where?

  _____
- ☐ Gore-Tex Implants - If yes, where?

  _____
- ☐ Aesthetic or Cosmetic Procedures
  If yes, where? _____
- ☐ Laser Treatments
  What type & why? _____

Physician's Name:_____

Address:_____

Phone:_____

Other Specialty:_____

Informed Consent
TO PROCEDURE

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1. Are you pregnant or nursing?
Yes [ ] No [ ]

Initial

2. I understand the initial procedure is a two-part process where a touch up procedure is required 6-12 weeks after my first visit. _____

3. I have received, reviewed, and understand the pre-procedural instructions as given to me and agree to follow them. _____

4. Depending on the procedure(s), which I select, I accept responsibility for determining the shape, and position of eyebrows, eyeliners, lipliner and/or full lip color. _____

5. I understand that the color selection and color results in all procedures are not an exact science. _____

6. I understand that positioning of my procedures can be affected if I have elected or wish to elect cosmetic surgery, Botox, Restalyne or any other cosmetic filler and I assume this responsibility. _____

7. I am aware that if I am to receive an MRI after the procedure, I must tell the Radiologist that I have iron oxide Permanent cosmetics. _____

8. If I am a contact lens wearer, I realize I should not wear my contacts the day of my eyeliner procedure. _____

9. I understand that this procedure will fade over time and this fading can alter the original pigment color which determines it is time for a touch-up visit. _____

10. I realize this is an elective cosmetic procedure and is not medically necessary. _____

11. I have pre-medicated where advised based upon the medical history I provided. _____

12. It has been explained to me that the following possibilities may occur: Minor and temporary bleeding, bruising, redness or other discoloration; swelling. _____

13. Although rare, Fever blisters may occur regardless of pre-medication. _____

14. I understand that many lasers & IPL's (Intense Pulse Lights) including those used for hair removal, anti-aging, Photo Facials, removal of lines, can turn permanent make up dark or even black. I agree to inform my esthetician or anyone operating such I have permanent make up. _____

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15. I give my consent for the practitioner to confer with my physicians for medical information required for the safety of my procedures. _____

16. I agree to accompany my practitioner to the emergency room in the event they were to be accidentally stuck with my needle and take a blood test for their safety & disclose all test results to my practitioner. _____

17. I am aware that if an infection occurs after I have received Permanent Cosmetics to see with my primary Physician or an emergency room, immediately _____

18. I understand there are no refunds on procedures. _____

ACCEPTANCE: Please read all questions thoroughly before signing!!

I have read and understand these risks listed above and they have been explained to me. I certify that the information in the above questionnaire is accurate and my questions have been answered.

Signature of Client X: _____

Practitioner Signature: _____Date:___/___/_____