Ink Brow Studio

CLIENT HEALTH HISTORY

Today's Date_____/_____/_____

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? ☐ No ☐ Yes

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 a day	Why it was prescribed to you?

Practitioner Signature_____**Date**_____/_____/_____

GENERAL MEDICAL

Client Name: _____

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? _____ Derma
- ☐ _____
  Active or in Flare-ups? _____ Hemophilia or Clottin
- ☐ 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	Swimming
Golf	Skiing
Gardening	Walking
Boating	Other

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: _____
Specialty: _____

Signature of Practitioner_____Date_____/____/_____

INFORMED CONSENT TO PROCEDURE

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

Signature of Practitioner_____**Date**_____/_____/_____