Medical History for Permanent Cosmetics

Information is strictly confidential. Please answer all questions to enable aesthetic care provider to make proper decisions based on your medical history.

Last Name _____ First: _____ DOB: _____

Procedure(s) Desired: Please check all that apply

Upper Eyeliner — Partial Eyebrows

Lower Eyeliner — Full Eyebrows

Other: _____

Allergies: Please check all that apply

Latex Rubber	Tattoo Ink/Pigment	Novovaine, Lidocaine
Benzocaine, Tetracaine	Lanolin	Bacitracin Ointment
Neomycin or Polymyxin B	PABA	Metal(s)

Foods: _____

Other Allergies: _____

Reaction: _____

Eyes/Eyebrows: Please check all that apply

Contact Lenses	Dry Eyes	Eye Makeup Sensitivities
Blurred Vision	Glaucoma	Lasik/Eye Surgery
Thyroid abnormalities	Alopecia Areata (local)	Alopecia Universalis (total)
Eyebrow/Lash Tinting	Date of last service: _____	
Botox	Date of last service: _____	

Other Hair Loss (describe): _____

Other Eye Disorders: _____

SKIN: Please check all that apply

Any other tattoos – Location: _____ Age of Tattoo: _____ Any Problems: _____

Use of sunlamp/Tanning Bed/Suntan Outdoors

Currently tanned in the area being treated

Current use of Retin A/Retinol, Glycolic, Alpha or Beta Acid (s) – Location : _____

Injectables such as Juvederm, Restylane or other fillers? Location: _____

Ever had a chemical peel? When: _____ Type of Peel: _____

Any keloid or Hypertrophic scars? – Location: _____

Do you bruise of bleed easily or have problems healing?

Other active skin disorders? Describe: _____

General Medical: Please check all that apply

Diabetes	Heart Palpitations	High Blood Pressure
Mitral Valve Prolapse	valve implants	Pregnant or nursing
Hemophilia of other clotting disorder		Taken Accutane within the last six months

Currently on blood thinners or anticoagulants such as Coumadin, Aspirin, Ibuprofen or alcohol?

Autoimmune disorders- Describe: _____

Do you have a condition of Hepatitis, HIV or undergoing treatment such as chemotherapy that could affect healing? _____

Seizures – Describe: _____

Current use of controlled substances? _____

Please list any surgeries: _____

Are you planning cosmetics or any other surgeries/Procedures in the near future?
Describe:_____

List all medications, prescriptions and non-prescriptions that you have taken in the last two weeks:

_____

Are you currently under a physicians care for any condition? Describe:

_____

Physicians Name: _____ City: _____ Phone: _____

I confirm that the answers to the questionnaire are true and correct. I also confirm that the consultant has clarified any questions I did not understand.

Signature of patient or Legal Guardian: _____Date: _____

Aesthetic Care Provider: _____Date: _____