MEDICAL PROFILE MICROPIGMENTATION

Name _____ Date of Appointment _____

Address _____ Date Of Birth _____

Telephone _____

TO AVOID UNFORESEEN COMPLICATIONS, PLEASE ANSWER THE FOLLOWING QUESTIONS.

Are you allergic to any metal? ☐ yes ☐ no

Have you had any aspirin or blood thinners in the past 2 weeks? ☐ yes ☐ no

Have you ever had any semi-permanent makeup procedures before? ☐ yes ☐ no

Any mood altering drugs within the last 8 hours? ☐ yes ☐ no

Are you on any immuno suppressive medications such anti-inflammatories or steroids? ☐ yes ☐ no

Do you have a history of cold sores, herpes, or fever blisters? ☐ yes ☐ no

Are you allergic to topical antibiotic preparations or desensitizers? ☐ yes ☐ no

Are you sensitive/allergic to latex? ☐ yes ☐ no

Is there any history of skin diseases or remarkable skin sensitivities? ☐ yes ☐ no

Have you had a chemical peel or laser? ☐ yes ☐ no. If so, Are you currently taking any vitamins A or E in any form?

If yes when? _____

Do you have problems healing? ☐ yes ☐ no

Are you pregnant or nursing? ☐ yes ☐ no

Are you currently undergoing radiation or chemotherapy? ☐ yes ☐ no

Are you required to take antibiotics during dental or invasive medical procedures? ☐ yes ☐ no

Are you currently using any retin-a or alpha-hydroxy skin care products? ☐ yes ☐ no

Previous problems with tattoos or has your physician advised you not to have a tattoo at this time? ☐ yes ☐ no

List all medications you are currently taking:

PLEASE CHECK ANY OF THE FOLLOWING WHICH MAY PERTAIN TO YOU

- ☐ Heart Conditions
- ☐ Allergies To Makeup
- ☐ Accutane Treatment
- ☐ Diabetes
- ☐ Stroke
- ☐ Chest Pains
- ☐ Alopecia
- ☐ Trichotilomania (compulsive desire to pull out one's hair)
- ☐ Keloid/Hypertrophy of Scars
- ☐ Epilepsy/Seizures
- ☐ Shortness Of Breath
- ☐ Autoimmune Disorder
- ☐ Cancer (any)
- ☐ HIV
- ☐ Hepatitis
- ☐ Jaundice Kidney Disease
- ☐ Tendency to develop Fever
- ☐ Ocular Herpes
- ☐ Hyper-pigmentation
- ☐ Hypo-pigmentation
- ☐ Tendency To Bleed Excessively From Minor Injuries
- ☐ Blisters on the lip

List any other medical conditions or issues not addressed above

Primary Physician's Name _____ Phone Number _____

BY SIGNING BELOW, I ACKNOWLEDGE, UNDERSTAND AND AGREE THAT

Practitioner do not practice medicine, does not accept health insurance, and have made no representation to the contrary; the information provided on this form is accurate and complete to the best of my knowledge, and that practitioner providing brows microblading is not responsible for complications or problems arising from any incorrect or omitted information. Some individuals will have complications related to semi-permanent makeup application. These complications are usually mild and last only a few days. However, extreme complications are always a possibility. I accept these risks and agree to hold practitioner from "Brows&Beauty" harmless for same; Practitioner from "Brows&Beauty" will use the information provided above to assess my suitability for the proposed micropigmentation services.

Client signature _____ Date _____