INTERLOCKS ™
MEDSPA + WELLNESS

PERSONAL INFORMATION

Name: _____ Date of Birth: _____

Street Address: _____

City : _____ State: _____ Zip Code: _____

Home Phone: _____ Okay to leave confidential message? Y / N

Cell Phone: _____ Okay to leave confidential message? Y / N

E-Mail: _____

Emergency Contact *Name:* _____ *Phone #:* _____

LASH HISTORY

Have you have any of the following eyelash or eyebrow treatments?

☐ Lash / Brow Tinting ☐ Semi Permanent Mascara ☐ Eyelash Perm/Lift ☐ Eyelash Extensions

Reaction? Y / N	*Reaction? Y / N*	*Reaction? Y / N*	*Reaction? Y / N*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Did you seek medical advise from a doctor or specialist as a result of any reaction? Y / N

_____

_____

_____

MEDICAL HISTORY

Please answer YES or NO to the below medical history questions:

	Y	N	N/A
Do you have any skin disorders or inflammation fo the skin?			
Do you have an eye disease or infection?			
Have you recently had eye surgery?			
Do you regularly expereince watery eyes, hyfever or seasonal allergies?			
Do you have Bells Palsy?			
Have you ever expereince a previous reaction to eye treatments?			
Do you wear contact lenses?			
Are you pregant or breastfeeding?			
Are you taking HRT?			
Have you been diagnosed with Blephartitis?			

Do you have any other health problems or medical conditions? Please list: _____

_____

_____

Have you ever had an allergic reaction to any of the following medications? Please check all that apply and describe the reaction you experienced.

☐	Acetone	
☐	Latex / band aids	
☐	Adhesives, glues or bonding agents	
	Other	

MEDICATIONS

What medications are you presently taking? Please list: _____

_____

_____

_____

_____

_____

Any other relevant information your Lash Artist should be informed of?

_____

_____

_____

I request and consent to lash procedures being carried out at INTERLOCKS without undergoing a sensitivity patch test. The sensitivity test, which if conducted, may indicate my sensitivity/ allergy to the products. _____ *Initial here*

I certify that the preceding medical, personal and lash history statements are true and correct. I am aware that it is my responsibility to inform my Lash Artist of my current medical or health conditions and to update my history. A current medical and lash history is essential to execute appropriate treatment procedures. I understand there are other treatment options available, including no treatment at all. I hereby authorize INTERLOCKS Lash Artist to perform lash services treatment on me. I acknowledge that all of my questions have been answered satisfactorily. I understand the lash services and accept the risks. I hereby release INTERLOCKS from all liabilities and absolve all other parties of their responsibilities, if any, associated with the supply of the products and service(s).

Signature:_____ Date: _____

Lash Artist:_____ Date: _____