SEMI-PERMANENT MAKEUP
& MICROBLADING

INTERLOCKS™
MEDSPA + WELLNESS

CONTACT 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 #:* _____

MEDICAL HISTORY

Are you currently under the care of a physician? Y / N

If yes, please explain: _____

Are you currently under the care of a dermatologist? Y / N

If yes, please explain: _____

Do you currently have any fillers or Botox®? Y / N

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

	Y	N	N/A
Are you allergic to any metal?			
Have you ever had any semi-permanent makeup procedures before?			
Do you have a history of cold sores, herpes, or fever blisters?			
Is there any history of skin diseases or remarkable skin sensitivies?			
Have you had a chemical peel or laser resurfacing? When?_____			
Do you have problems healing skin wounds?			
Are you currently pregnant or trying to conceive?			
Are you currently breastfeeding?			
Are you currently undergoing radiation or chemotherapy?			
Do you wear contact lenses? **If yes, they must be removed during eyeliner proceedure and cannot be replaced until the following day*			
Have you experienced any previous problems with tattoos or has your physican advised you to not have a tattoo at this time?			

Do you have any of the following medical conditions? Please check all that apply.

☐ Cancer	☐ Heart Conditions	☐ Allergies to Makeup	☐ Dry Eyes
☐ Accutane Treatment	☐ Cold Sores/Blisters on Lips	☐ Epilepsy/Seizures	☐ HIV/AIDS
☐ Glaucoma	☐ Trichotillomania	☐ Refractive Eye Surgery	☐ Stroke
☐ Kidney Disease	☐ Autoimmune Disorder	☐ Keliod/Hypertrophy of Scars	☐ Diabetes
☐ Alopecia	☐ Ocular Herpes	☐ Tendency to Develop Fever	☐ Hepatitis
☐ Shortness of Breath	☐ Hyper or Hypopigmentation	☐ Tendency to Bleed Excessively	☐ Chest Pain

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

_____

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

☐	Any metal	
☐	Latex	
☐	Asprin	
☐	Lidocaine	
☐	Topical Antibiotic Preparations or Deseneitizers	
☐	Food	

MEDICATIONS

Have you taken Aspirin or blood thinners in the past week? Y / N Please list all. _____

_____

Have you taken mood-altering or anti-depressant medication within the last 8 hours? Y / N

Are you on any immunosuppressive medication such as anti-inflammatories or steroids?? Y / N

Are you currently taking any Vitamin A or Vitamin E in any form? Y / N

What oral medications are you presently taking? Please include hormones and/or birth control if applicable.

_____

_____

What herbal supplements do you use regularly? _____

_____

Primary Physician's Name: _____

Primary Physician's Phone Number: _____

I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform my Certified Micropigment Specialist of my current medical or health conditions and to update my history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

By signing below I acknowledge, understand, and agree that:

- INTERLOCKS does not accept health insurance and have made no representation to the contrary
- 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 INTERLOCKS harmless.
- The INTERLOCKS Certified Micropigment Specialists will use the information I have provided to assess my suitability for the proposed micropigmentation services.

_____ Date: _____

Client Signature *(or guardian if under 18 years of age)*

*Guardian Name (Printed):*_____