

**CONFIDENTIAL MEDICAL PROFILE**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Client Name:  |  |  |  Date |  |
| Date of Birth: |  |  Age: |
| Address: |  |  |  |  |  |  |  |  |  |
| Phone: |  |  |  |  |  |  |  |  |  |
| Allergies: |  |  |  |  |  |  |  |  |
| **Please circle the answer that applies:** |
| YES | NO | Are you under the age of 18? |
| YES | NO | Are you pregnant or nursing? |
| YES | NO | Have you had any blood thinning agents in the last 7 days? |
| YES | NO | Have you had any mood altering agents within the last 24 hours? |
| YES | NO | Do you have a history of herpes, cold sores, or fever blisters? |
| YES | NO | Do you have a history of skin disorders or remarkable skin sensitivities? |
| YES | NO | Do you have problems with healing? |
| YES | NO | Have you had any permanent makeup procedures before? |
| YES | NO | Have you had any previous problems with tattoos/permanent makeup? |
| YES | NO | Are you currently undergoing chemotherapy or radiation? |
| YES | NO | Are you currently using Retin A or alpha-hydroxy skincare products? |
| YES | NO | Have you had a chemical laser peel in the last 30 days? |
| YES | NO | Do you wear contact lenses or false eyelashes? |
| **Please circle all that apply:** |  |  |  |  |
| Heart Disease |  |  |  |  | Alopecia |
| Kidney Disease | Trichotillomania |
| Hepatitis |  |  |  |  | Dry Eyes |
| HIV |  |  |  |  |  |  |  | Glaucoma |
| Cancer |  |  |  |  | Refractive Eye Surgery |
| Diabetes |  |  |  |  | Hyper-pigmentation |
| Stroke |  |  |  |  |  |  |  | Hypo-pigmentation |
| Epilepsy |  |  |  |  | Keloid Formation |
| Autoimmune Disorder | Bleeding Disorder |
| Herpes |  |  |  |  | Cold Sores/Fever Blisters |

Please list all medications you are currently taking:

Practitioner makes no attempt, or claim, to practice medicine. Some individuals will have complications related to permanent makeup application. These complications are usually mild and last only a few days. However, extreme complications are always a possibility. By signing this consent you are acknowledging that you are in good health and there are no apparent reasons to restrict you from receiving a tattoo.

Client Signature: Date:

For Office Use Only

Pigment MFR/Lot/EXP: Needle Size: