Orchids
PERMANENT MAKEUP STUDIO

CLIENT HISTORY

Name: _____ Date of Birth:_____ Today's Date:

Address:
Street City State Zip

Home Phone: Business Phone:

Cell Phone: May we contact you at these numbers?

Email Address: Referred by:

Ethnic Background (include all nationalities)

Emergency Contact: Phone Number:

PROCEDURE(S) DESIRED: Check all of the following that apply.

- ☐ Upper eyeliner ☐ Partial eyebrows ☐ Lip liner ☐ Beauty mark
- ☐ Lower eyeliner ☐ Full eyebrows ☐ Full lip color ☐ Scar Camouflage
- ☐ Other:

ALLERGIES: Check if you have ever had an allergic reaction to any of the following and described what happened below.

- ☐ Latex rubber ☐ Tattoo ink/pigment ☐ Novocain, Lidocaine ☐ Benzocaine, Tetracaine
- ☐ Lanolin ☐ Bacitracin Ointment ☐ Neomycin or polymyxin B ointment
- ☐ PABA ☐ Metal(s)
- ☐ Foods:

Other allergies:

Reaction:

EYES/EYEBROWS: Check all of the following that apply.

- ☐ Contact lenses ☐ Dry eyes ☐ Eye makeup sensitivities ☐ Blurred Vision
- ☐ Glaucoma ☐ Lasik /eye surgery ☐ Thyroid abnormalities ☐ Alopecia Areata (local)
- ☐ Alopecia Universalis (total) ☐ Pull out lashes/eyebrow compulsively (Trichotillomania)
- ☐ Other hair loss (describe):
- ☐ Eyebrow/Lash tinting
  Date of last service:
- ☐ Botox
  Date of last service:

Other eye disorders:

LIPS: Check all of the following that apply.

- ☐ Cold sores/fever blisters/herpes. If yes, an antiviral prescription is required prior to any lip procedure.
- ☐ Lip injections - Type: Date:
- ☐ Other lip augmentation - Type: Date:
- ☐ Teeth bleaching - Date:

SKIN: Check all of the following that apply.

- ☐ Any other tattoos - Location:
  Age of tattoo: Any problems:
- ☐ Use of sun lamp/tanning bed/sun tanning outdoors ☐ Currently tanned in the area being treated.
- ☐ Currently use Retin A - Location: ☐ Currently using glycolic acid, AHA or Retinol?
- ☐ Injectables such as Restylane, Juvederm or other fillers?
- ☐ Ever had a chemical peel? When: ☐ Type of peel:
- ☐ Do you have a scar you want camouflaged? Age of Scar:
- ☐ Any keloid or hypertrophic scars? - Location:
- ☐ Do you bruise or bleed easily? ☐ Do you have healing problems?
- ☐ Other active skin disorders? Describe:

GENERAL MEDICAL: Check all of the following that apply.

- ☐ Diabetes ☐ Heart Palpitations
- ☐ High blood pressure ☐ Mitral valve prolapse or valve implants
- ☐ Pregnant or nursing ☐ Hemophilia or other clotting disorders
- ☐ Taken Accutane within the last 6 months
- ☐ Currently on blood thinners or anticoagulants such as Coumadin, aspirin, ibuprofen, alcohol?
- ☐ Autoimmune disorders - describe:
- ☐ Do you have a condition such as Hepatitis, HIV or undergoing treatment such as chemotherapy that could affect healing?
- ☐ Seizures - describe:
- ☐ Current use of controlled substances - describe:

Please list any surgeries:

If you are planning cosmetic or other surgeries/procedures in the near future, describe:

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

If you are currently under a physician's care for any condition, describe:

Physician's Name: City: Phone:

This history has been reviewed by the technician and my questions have been satisfactorily answered.
I have also received and reviewed a copy of the Pre-Procedure Information Sheet and the After Care Sheet. I understand them and agree to follow them.

Signature: Date: