

## Designs in Permanent Make-up by Kathleen Nelson Client History Form

Name	Date of Service	E-mail
Address	City	State/Zip
How did you select me for your procedure services?	Ph-Home  Ph-Cell	Emergency contact

1	YES	NO	Do you have any allergies/sensitivities to latex? Hair dyes? Make-up? Petroleum-based products? Metals (e.g. nickel, gold, iron, aluminum, etc Hand creams or body lotions?)	15	YES	NO	Do you have prosthetic implants? List.
2	YES	NO	To your knowledge are you allergic or resistant to over-the-counter numbing products such as ELA-Max?	16	YES	NO	Have you ever had any permanent cosmetics or tattoos applied?
3	YES	NO	Are you undergoing radiation or chemotherapy treatment?	17	YES	NO	Do you routinely use Retin-A, glycolic, or other exfoliating products?
4	YES	NO	Do you consume aspirin daily?	18	YES	NO	Have you ever had cold sores or fever blisters?
5	YES	NO	Do you have a history of any type of hepatitis?	19	YES	NO	Do you intentionally tan -Direct sun or tanning bed?
6	YES	NO	Do you bruise easily for no obvious reason? Are you anemic?	20	YES	NO	Do you use tobacco? If you use tobacco you may heal slower and this affects the timing for scheduling a touchup appointment, if applicable.
7	YES	NO	Are you diabetic? If so, Type 1 or Type 2?	21	YES	NO	Do you wear contact lenses?
8	YES	NO	Do you have any autoimmune disorders?	22	YES	NO	Have you had any alcohol in the last 24 hours?
9	YES	NO	Do you have high or low blood pressure?	23	YES	NO	Do you have a tendency to faint or become dizzy?
10	YES	NO	Do you have a history of stroke or heart attack?	24	YES	NO	Are you under treatment for depression?
11	YES	NO	Do you have glaucoma or any other eye disease?	25	YES	NO	Do you take prescription drugs?
12	YES	NO	Do you have any problems healing?	26	YES	NO	Do you menstruate? If yes: Next cycle date
13	YES	NO	Do you tend to develop keloid or hypertrophic scars?	27	YES	NO	Are you pregnant or nursing?
14	YES	NO	Do you hypo-pigment? (Lack of pigment on the skin)? Hyper-pigment (tendency to develop dark spots on the skin from wounds or sun)?	28	YES	NO	Do you have any medical condition that has resulted in a medical professional requiring you to pre-medicate with an antibiotic prior to any dental or other invasive procedures?

**If you answered "Yes" to any questions above, use the space below and the reverse side of this form to provide an explanation.**

**Correlate your explanations to a specific question number.** A "yes" answer does not indicate you are not an acceptable candidate for permanent cosmetics. It may simply be information that is valuable to me as your technician as each person's body is unique, or it may indicate that based on any health conditions that affect healing, it would be advisable or required for you to consult with your physician before proceeding. . If this form has not addressed a medical condition you have, please list it below.


Client Signature \_\_\_\_\_ Date \_\_\_\_\_