Confidential Medical Profile

Name _____ Date_____

Address _____

Daytime Phone _____ Cell _____

How did you hear about us? _____

To avoid unforeseen complication, please answer the following questions, circle either **Y** for **Yes** or **N** for **No**:

Y or N Are you under the age of 18? If Yes- Legal guardians initials:_____

Y or N Have you had any aspirin or blood thinning products within the last 7 days?

Y or N Any mood altering drugs within the last 8 hours?

Y or N Do you have any history of cold sores, herpes, or fever blisters?

Y or N Are you sensitive to Latex?

Y or N Have you had a chemical or laser peel? If so, when?

_____

Y or N Do you have problems with healing?

Y or N Previous problems with tattoos or has your physician advised you not to have a tattoo at this time?

Y or N Are you currently undergoing radiation or chemotherapy?

Y or N Are you currently using Retin-A or “Alpha Hydroxy” skin care products?

Y or N Do you wear contact lenses? (If yes, I understand they must be removed during my eyeliner procedure and should not be replaced until the next day: Initials____)

Y or N Are you allergic to any metal? (e.g. you can only wear 14k gold)

Y or N Is there any history of skin diseases or remarkable skin sensitivities?

Y or N Are you presently taking Vitamins A and/or E in any form?

Y or N Are you pregnant or nursing?

Y or N Are you required to take antibiotics during dental or invasive medical procedures?

Y or N Are you currently using Latisse? If so, how long have you used it?

_____

Y or N If you have used Latisse and have stopped, when was the last date of use? _____ how long had you used it for?_____

Please Check any of the following which pertain to you:

Heart Conditions__

Dry Eyes__

Diabetes__

Shortness of breath__

Epilepsy/seizures of any kind__

Accutane treatment__

Refractive Eye Surgery__

Trichotillomania__

Hepatitis/jaundice/HIV__

Allergies to makup__

Keloid or hypertrophy scars__

Stroke__

Alopecia__

Chest Pains__

Autoimmune disorders__

Glaucoma__

Cancer (any type) __

Kidney disease__

Tendency to develop fever__ Blisters on the lip__

Tendency to bleed excessively from minor injuries__

Keloid Formation__

Hyper-pigmentation (darkening of the skin) __

Hypo-pigmentation (lightening of the skin)__

Diabetes__ Ocular herpes__

Please explain any checked questions and list any other medical conditions and also list ALL your medications:

_____
_____
_____
_____
_____
_____
_____
_____

Doctors Name_____ Phone Number_____

Client Signature_____ Date_____