Semi-Permanent Makeup
Medical History Form

Name			
Address		**Home Phone**	
		Mobile Phone	
		Email	
Date of Birth		**How did you hear about us?**	
Allergies to Medication		**Current Medication being taken**	
Any Major Surgery in the last 12 months?		**Dates**	

Are you currently:	**YES**	**NO**
In Menopause?		
Post Menopause?		
Having Regular Periods?		
Suffering from Hormone Imbalance?		
Pregnant?		
Taking Hormone Supplements?		
Taking Contraception Measures?		
Do you have any of the following?	**YES**	**NO**
Acne		
Cold Sores		
Contact Lenses		
Dermatitis/Eczema		
Diabetes		
Genital Herpes		
Latex Allergy		
Tattoos		
Shingles		
Hearing Aid		
Heart Condition		
Haemophilia		
Hepatitis		
HIV		
Continues Overleaf		

Continued	YES	NO
Keloid Scars		
Any Metal in your body		
Moles		
Pacemaker		
Bleeding Disorders		
Problems with healing		

Please rate your skin type based on the following scale as well as personal experience		
Type I	Always Burns, Never Tans	
Type II	Usually burn, tan less than average and with difficulty	
Type III	Sometimes burn mildly, tan about average	
Type IV	Rarely Burn, tan more than average (with ease)	

Have you ever had any previous treatment for hair removal?	
If Yes, please specify where	

Have you ever had any (Circle as applicable)		
Accutane	Laser Resurfacing	Sunburn
Retina Burns	Liposuction	Pulsed Dye Laser
Chemical Peel	Photo-Derm	Skin Grafts
Glycolic Acid	Intense Light	

On Any of these areas		
Forehead	Lips	Underarms
Eyebrows	Chin	Shoulders
Eyelids	Neck (Hair Line)	Arms
Upper Lip Area	Cheeks	Hands/Fingers
Breast	Chest	Arms
Abdomen	Back	Bikini Line
Legs	Thighs	Buttocks
Feet/Toes		

I confirm that the information provided by me is Complete, accurate and true to the best of my knowledge

Signature		**Date**	