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** |  |