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** | | |  | |