Beauty & Beyond
Permanent Cosmetics and Full Service Salon

## Confidential Medical Profile

**Name** _____ **Date** _____

**Occupation** _____ **Phone #**_____

**To avoid unforeseen complications, please answer the following questions:**

**Y N** Are you over the age of 18? Legal guardian's initials: _____
**Y N** Have you had any aspirin or blood thinning products within the last 7 days?
**Y N** Any mood altering drugs within the last 8 hours? (i.e. Wellbutrin, Xanax, Prozac)
**Y N** Do you have any history of cold sores, herpes, or fever blisters?
**Y N** Are you sensitive to Latex?
**Y N** Have you had a chemical or laser peel?
**Y N** Do you have problems with healing?
**Y N** Previous problems with tattoos or has your physician advised you not to have a tattoo at this time?
**Y N** Are you currently undergoing radiation or chemotherapy?
**Y N** Are you currently taking any chemotherapy medications?
**Y N** Are you currently using Retin-A or "Alpha Hydroxy" skin care products? (If so, avoid use for 1 month following procedure)
**Y N** Do you wear contact lenses?
**Y N** Are you allergic to any metal? (e.g. Can only wear 14k gold) _____
**Y N** Have you ever had any permanent makeup procedures before? Area?When?

_____
**Y N** Medication, including immunosuppressive, such as anti-inflammatory or steroids?
**Y N** Withdrawal from caffeine products?
**Y N** Are you allergic to topical antibiotic numbing creams or desensitizers?
**Y N** Is there any history of skin diseases or remarkable skin sensitivities?
**Y N** Are you taking any vitamins?
**Y N** Are you pregnant, trying or nursing?
**Y N** Are you required to take antibiotics during dental or invasive medical procedures?
**Y N** Do you have any drug allergies? If yes, list in space provided at the end of the form.
**Y N** Are you currently taking medication for high or low blood pressure?
**Y N** **Did you work out today?**
**How many times a week do you work out?**

_____
**Y N** **Have you consumed alcohol today?**

**Do you, or have you had, any of the following:**

**[ ]** Tuberculosis **[ ]** MRSA/STAPH
**[ ]** Heart condition/Pace Maker/Defibrillator
**[ ]** Trichotillomania [ ] Eczema/Dermatitis
**[ ]** Allergies to makeup **[ ]** Hepatitis/Jaundice/HIV
**[ ]** Accutane treatment **[ ]** Kidney Disease
**[ ]** Dry eyes **[ ]** Cold sores
**[ ]** Keloids **[ ]** Tendency to bleed
**[ ]** Glaucoma [ ] Thyroid Issues
**[ ]** Diabetes **[ ]** Hyper-pigmentation

[ ] Stroke
[ ] Chest pains
[ ] Shortness of breath
[ ] Alopecia
[ ] Epilepsy/seizures
[ ] Smoker
[ ] Cataract surgery
[ ] Tear duct plugs
[ ] Planning on having Facial Plastic Surgery
[ ] Cancer (List below)
[ ] Head Injury/Trauma

[ ] Hypo-pigmentation
[ ] Herpes Simplex
[ ] Refractive eye surgery
[ ] Autoimmune disorders
[ ] Shingles
[ ] Eyelid surgery
[ ] Lasik surgery
[ ] Ocular Herpes

[ ] Tan Regularly?
[ ]Laser removal of brows
[ ] Facelift/Forehead/Brow Lift (When)_____
[ ] Scar/s in area
[ ] Eyebrow Transplant
[ ] Psoriasis
[ ] Oily/Severely Oily skin
[ ] Botox/Fillers- Area/s_____

**Other Medical Conditions: (LIST BELOW)**

***Practitioner makes no attempt to, or claim to, practice medicine. Some individuals will have complications related to permanent makeup application. These complications are usually mild and last only a few days. However, extreme complications are always a possibility. If you are healthy and there are no visible reasons restricting you from receiving a tattoo, you must approve of the design and color before the application of your permanent makeup.***

## Confidential Medical Profile

**Name** _____ **Date** _____

**Referred By** _____

**Please explain any checked question, list any other medical conditions or allergies, and list all your medications:**

_____

_____

_____

_____

*Client's Signature* *Date*