

**CONFIDENTIAL MEDICAL PROFILE**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Client Name: | | | | | |  | |  | Date | |  |
| Date of Birth: | | | | | | | |  | Age: | | |
| Address: | | |  |  |  |  |  |  |  |  |  |
| Phone: | |  | |  |  |  |  |  |  |  |  |
| Allergies: | | | |  |  |  |  |  |  |  |  |
| **Please circle the answer that applies:** | | | | | | | | | | | |
| YES | NO | | | Are you under the age of 18? | | | | | | | |
| YES | NO | | | Are you pregnant or nursing? | | | | | | | |
| YES | NO | | | Have you had any blood thinning agents in the last 7 days? | | | | | | | |
| YES | NO | | | Have you had any mood altering agents within the last 24 hours? | | | | | | | |
| YES | NO | | | Do you have a history of herpes, cold sores, or fever blisters? | | | | | | | |
| YES | NO | | | Do you have a history of skin disorders or remarkable skin sensitivities? | | | | | | | |
| YES | NO | | | Do you have problems with healing? | | | | | | | |
| YES | NO | | | Have you had any permanent makeup procedures before? | | | | | | | |
| YES | NO | | | Have you had any previous problems with tattoos/permanent makeup? | | | | | | | |
| YES | NO | | | Are you currently undergoing chemotherapy or radiation? | | | | | | | |
| YES | NO | | | Are you currently using Retin A or alpha-hydroxy skincare products? | | | | | | | |
| YES | NO | | | Have you had a chemical laser peel in the last 30 days? | | | | | | | |
| YES | NO | | | Do you wear contact lenses or false eyelashes? | | | | | | | |
| **Please circle all that apply:** | | | | | | | |  |  |  |  |
| Heart Disease | | | |  |  |  |  | Alopecia | | | |
| Kidney Disease | | | | | | | | Trichotillomania | | | |
| Hepatitis | | | |  |  |  |  | Dry Eyes | | | |
| HIV |  |  |  |  |  |  |  | Glaucoma | | | |
| Cancer | | | |  |  |  |  | Refractive Eye Surgery | | | |
| Diabetes | | | |  |  |  |  | Hyper-pigmentation | | | |
| Stroke |  |  |  |  |  |  |  | Hypo-pigmentation | | | |
| Epilepsy | | | |  |  |  |  | Keloid Formation | | | |
| Autoimmune Disorder | | | | | | | | Bleeding Disorder | | | |
| Herpes | | | |  |  |  |  | Cold Sores/Fever Blisters | | | |

Please list all medications you are currently taking:

Practitioner makes no attempt, 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. By signing this consent you are acknowledging that you are in good health and there are no apparent reasons to restrict you from receiving a tattoo.

Client Signature: Date:

For Office Use Only

Pigment MFR/Lot/EXP: Needle Size: