**Confidential Medical Profile - Micropigmentation**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**To Avoid Unforeseen Complications, Please Answer The Following Questions**

|  |  |
| --- | --- |
| Are you under 18? □yes □ no If so, guardians initials\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Are you allergic to any metal? □yes □ no |
| Have you had any aspirin or blood thinners in the past week? □yes □ no | Have you ever had any semi-permanent makeup procedures before? □yes □ no |
| Any mood altering drugs within the last 8 hours? □yes □ no | Are you on any immunosuppressive medications such anti-inflammatories or steroids? □yes □ no |
| Do you have a history of cold sores, herpes, or fever blisters? □yes □ no | Are you allergic to topical antibiotic preparations or desensitizers? □yes □ no |
| Are you sensitive/allergic to latex? □yes □ no | Is there any history of skin diseases or remarkable skin sensitivities? □yes □ no |
| Have you had a chemical peel or laser?□ yes □ no If so, when?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Are you currently taking any vitamins a or e in any form? □yes □ no |
| Do you have problems healing? □yes □ no | Are you pregnant or nursing? □yes □ no |
| Are you currently undergoing radiation or chemotherapy? □yes □ no | Are you required to take antibiotics during dental or invasive medical procedures? □yes □ no |
| Are you currently using any Retin-A or alpha-hydroxy skin care products? □yes □ no | Do you wear contact lenses? (if yes I understand they must be removed during my eyeliner procedure and should not be replaced until the next day) □yes □ no |
| Previous problems with tattoos or has your physician advised you not to have a tattoo at this time? □yes □ no |  |

List all medications you are currently taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please Circle Any Of The Following Which May Pertain To You**

|  |  |  |  |
| --- | --- | --- | --- |
| **Heart Conditions** | **Allergies To Makeup** | **Accutane Treatment** | **Dry Eyes** |
| **Diabetes** | **Stroke** | **Chest Pains** | **Alopecia** |
| **Refractive Eye Surgery** | **Glaucoma** | **Trichotillomania** | **Keloid/Hypertrophy Of Scars** |
| **Epilepsy/Seizures** | **Shortness Of Breath** | **Autoimmune Disorder** | **Cancer (Any)** |
| **Hepatitis/ Jaundice** | **HIV** | **Kidney Disease** | **Tendency To Develop Fever** |
| **Blisters On The Lip** | **Ocular Herpes** | **Hyperpigmentation** | **Hypopigmentation** |
| **Tendency To Bleed Excessively From Minor Injuries** | **Adverse Reaction to Anesthesia** |  |  |

List any other medical conditions or issues not addressed above: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Physician’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Physician’s Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By signing below, I acknowledge, understand and agree that:

* the staff at iBrow-ology do not practice medicine, does not accept health insurance, and have made no representation to the contrary;
* the information provided on this form is accurate and complete to the best of my knowledge, and that iBrow-ology is not responsible for complications or problems arising from any incorrect or omitted information;
* some individuals will have complications related to semi-permanent makeup application. These complications are usually mild and last only a few days. However, extreme complications are always a possibility. I accept these risks and agree to hold \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_of iBrow-ology and its employees and contractors harmless for same;
* the staff at iBrow-ology will use the information provided above to assess my suitability for the proposed micropigmentation services.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

**Client signature (or guardian if under 18 years of age) Date**