**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**