CONFIDENTIAL MEDICAL FORM

NAME:_____ DOB:_____ AGE:_____ DATE:_____

Email: _____ Phone number: _____

ADDRESS: _____

CITY: _____STATE: _____ZIP: _____

Do you have any previous tattoo/Permanent Makeup: Yes_____ No_____ how long ago you did have it done? _____

First Session: _____ 6-8 weeks Touch Up: _____ Annual Touch up: _____

Select procedure:

MICROBLADING_____ Microblading & Shading. _____

Please mark Yes or No.

Are you currently under the care of a physician: YES_____ NO_____

If so, explain: _____.

Physician Name: _____.

Are you taking any medication? Yes: _____ NO: _____

If so, explain: _____.

Within last 48 hrs., Have you taken/drank any of the following? Mark Yes or No.

Aspirin: _____

Advil/Tylenol: _____

Retin A: _____ if so,
explain: _____

Antibiotics: _____

Blood thinning medication: _____ If yes,
explain: _____

Alcohol: _____

Coffee: _____

Energy Drinks: _____

In the following questions, answer with your initials in the corresponding answer.

Heart condition:	Yes: _____	No: _____	Eczema.	Yes: _____	No: _____	Alopecia:	Yes: _____	No: _____
Diabetic:	Yes: _____	No: _____	TB:	Yes: _____	No: _____	Epilepsy:	Yes: _____	No: _____
Herpes	Yes: _____	No: _____	Asthma:	Yes: _____	No: _____	Herpes:	Yes: _____	No: _____
hypertension:	Yes: _____	No: _____	Psoriasis:	Yes: _____	No: _____	Pregnant:	Yes: _____	No: _____
Hemophilia:	Yes: _____	No: _____	HIV:	Yes: _____	No: _____			

OTHERS: Yes: _____ No: _____ If so, explain: _____

Allergies: Yes: _____ No: _____ If so, explain: _____

Moles/freckles on your brows: Yes: _____ No_____

I confirmed that what I have answered in the previous question is true and affirmed that it coincides with my person.

Client Signature: _____ Date: _____