PERMANENT MAKEUP

FORM ①

CONTRAINDICATIONS & MEDICAL HISTORY

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1.	Are you pregnant or breast feeding?	YES ○ NO ○
2.	Have you had any alcohol in the last 24 hours?	YES ○ NO ○
3.	Have you had caffeine drinks, caffeine supplements or energy drinks e.g. red bull in the past 24 hours?	YES ○ NO ○
4.	Do you take prescription drugs?	YES ○ NO ○
5.	Do you smoke or use any nicotine products?	YES ○ NO ○
6.	Have you had a laser or chemical peel within 6 months?	YES ○ NO ○
7.	Have you ever had any permanent cosmetics or tattoos applied?	YES ○ NO ○
8.	If you have permanent cosmetics or tattoos did you have any problems with healing after they were applied?	YES ○ NO ○
9.	Have you had problems with colour retention in previous tattoos?	YES ○ NO ○
10.	Have you recently had facial cosmetic surgery?	YES ○ NO ○
11.	Do you have any scars in the proposed treatment area?	YES ○ NO ○
12.	Do you bruise easily?	YES ○ NO ○
13.	Do you hyperpigment (darken) when the skin is compromised?	YES ○ NO ○
14.	Do you hypopigment (lighten) when the skin is compromised?	YES ○ NO ○
15.	Do you develop keloid or hypertrophic (raised) scars?	YES ○ NO ○
16.	Do you scar easily from minor skin injuries?	YES ○ NO ○
17.	Do you bleed excessively from minor cuts?	YES ○ NO ○
18.	Do you have any problems healing from small wounds?	YES ○ NO ○
19.	Do you wear contact lenses?	YES ○ NO ○
20.	Do you use Retin-A®, glycolic, or other exfoliating products?	YES ○ NO ○
21.	Do you use Latisse® or any other eyelash growth product?	YES ○ NO ○
22.	Do you have prosthetic implants?	YES ○ NO ○
23.	Do you consume Aspirin on a daily basis?	YES ○ NO ○
24.	Do you have a history of cold sores/fever blisters?	YES ○ NO ○
25.	Do you have Botox® injections?	YES ○ NO ○
26.	Do you intentionally tan – direct sun or tanning bed?	YES ○ NO ○
27.	Have you ever used the acne treatment Accutane®?	YES ○ NO ○
28.	Do you have a history of skin sensitivities?	YES ○ NO ○
29.	Do you have allergies to topical makeup?	YES ○ NO ○
30.	Have you ever had an allergic reaction to any of the following products; (A)Bacitracin, Neomycin, Polymcin, and Lanolin (these can be ingredients of topical and antibiotic creams) or propylene glycol?	YES ○ NO ○
31.	Are you allergic or sensitive to any metals, for instance, metals used for jewellery, e.g. Nickel?	YES ○ NO ○

by Louise
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32. Are you sensitive to petroleum-based products?	YES ◯	NO ◯
33. Do you have an allergy to latex?	YES ◯	NO ◯
34. Are you allergic to eyelash/eyebrow or hair tints?	YES ◯	NO ◯
35. Are you sensitive or allergic to hand creams or body lotions?	YES ◯	NO ◯
36. Do you have dry eyes?	YES ◯	NO ◯
37. Are you menstruating?	YES ◯	NO ◯
38. Have you ever experienced problems being anaesthetised?	YES ◯	NO ◯
39. Have you ever had a reaction to Novocaine or Lidocaine?	YES ◯	NO ◯
40. Do you have abnormally high or low blood pressure?	YES ◯	NO ◯
41. Do you have any seizure related conditions?	YES ◯	NO ◯
42. Do you have a tendency to become faint or dizzy?	YES ◯	NO ◯
43. Do you have a history of cancer?	YES ◯	NO ◯
44. Are you undergoing radiation or chemotherapy treatment?	YES ◯	NO ◯
45. Do you have a history of stroke or heart attack?	YES ◯	NO ◯
46. Do you have any other heart conditions?	YES ◯	NO ◯
47. Do you have a pacemaker or any other medical implant?	YES ◯	NO ◯
48. Are you diabetic?	YES ◯	NO ◯
49. Are you anaemic?	YES ◯	NO ◯
50. Do you have Glaucoma?	YES ◯	NO ◯
51. Do you have a Thyroid condition?	YES ◯	NO ◯
52. Do you suffer from Alopecia?	YES ◯	NO ◯
53. Do you have any auto-immune disorders?	YES ◯	NO ◯
54. Have you ever been diagnosed with Hepatitis B/C or HIV?	YES ◯	NO ◯
55. Do you have any skin conditions such as Scleroderma?	YES ◯	NO ◯
56. Do you have Lupus?	YES ◯	NO ◯
57. Do you suffer from Acne, Dermatitis, Eczema, Psoriasis, any undiagnosed rashes or blisters?	YES ◯	NO ◯
58. Are you 18 years old or over?	YES ◯	NO ◯
59. Do you have any medical conditions not mentioned on this form?	YES ◯	NO ◯
60. Do you take Warfarin or any other anticoagulant medication?	YES ◯	NO ◯

Lily Louise
THE BEAUTY ROOM
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FIRST NAME (CAPITALS): _____

SURNAME (CAPITALS): _____

SIGNATURE: _____ DATE: _____

PRACTITIONER SIGNATURE: _____