THE ART OF PERMANENT COSMETICS

404-430-2425 B Lashfull Boudoir

Please Review this Medical Health Form prior to scheduling your Microblading Procedure

- **Please be prepared to list all of the medications you have taken in the last 6 months.**

Review the questions below and provide honest, up-to date responses. It is your responsibility to complete and sign a physical copy of the Medical Health Form provided the day of your Microblading procedure. Based on your responses you may not be eligible to receive a Microblading procedure.

Have you taken any of the following in the last 2 days?

Aspirin, Ibuprofen,

Yes/No...

Have you received chemotherapy or radiation treatment in the last year? Yes/No

Name of Doctor:

Surgery:

Allergies: Have you ever had an allergic reaction to any of the following:

Lanolin Latex Rubber Nuts
Medication Metals Hair dyes
Drugs Foods Lidocaine
Paints Crayons Glycerine
Antibiotic ointments Anesthetics

Other allergies:

Have you had a dental injection to numb your mouth?

Yes/No

Are you presently pregnant or breast feeding? Yes/No
MRI scan scheduled in the next 3 months? Yes/No

Laser or IPL scheduled in the next 3 months? Yes/No

Do you give blood?Yes/No

Prior to dental procedures do you receive antibiotic therapy?

Yes/No

Have you had Botox or other injectables?

Yes/No

Are you currently under the care of a doctor or hospital specialist?

Yes/No

If "Yes" please list relevant details of Doctor and condition currently being treated:

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Please review the following and check any medical or mental condition(s) that apply to you:

Abnormal Heart Condition

Palpitations

Body Dysmorphic Disorder (BDD)

Mitral Valve Prolapsed

Heart Murmur

Depression

Rheumatic Fever

Pacemaker

Artificial Heart Valves

Low-Self Esteem

Anemia

Hemophilia

Prolonged Bleeding

High Blood Pressure

Low Blood Pressure

Circulatory Problems

Diabetes

Epilepsy

Fainting Spells or Dizziness

Thyroid Disturbances

Liver Disease

Kidney Disease

Glaucoma

Stomach Ulcers

Tumors, Growths or Cysts

Cancer

Tuberculosis

Stroke

HIV

Prosthetic Hip or Joint

Systemic Lupus Erythematosus

Hepatitis

Shingles

Cataracts

Blurred Vision

Dry Eyes

Do you suffer from eye Infections?

Alopecia

Ocular Herpes

Watery Eyes

Contact Lenses

Eyelid Surgery

Severely Chapped Lips

Trichollomania

Recent Hair Loss

Cold Sores (Herpes simplex)

Auto Immune Conditions

Gore-Tex Implants/Silicone Injections

Other Tattoos

Fat Transfer Enhancement

Bruise or Bleed Easily

Botox Enhancement

Frequent Use of Sun bed

Dermal Fillers (Example: Restylane)

Date of last Eyelash/Eyebrow tint:

Do you have problems healing from a wound?

Have you had a Chemical or Laser Peel procedure within the last 6 months?

Do you scar in a raised manner?

Have you been prescribed Retin-A within the last 6 months?

Do your scars heal a darker color than the rest of your skin?

Have you had any AHA preparations within the last 2 weeks?

Do you experience Keloid Scars?

Do have a sensitivity to color or skincare cosmetics?

Have you used Accutane within the last 6 months?

Do you tan regularly (Sunlight)?

Have you used steroids within the last 6 months?

Please list any other medical condition you experience that is not listed above:
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Have you had a Micropigmentation procedure before? Yes/ No

If "Yes", please list: Date of procedure, business name, and level of satisfaction with the results..

I give my consent for Micropigmentation work to be provided – which is undertaken at my request and in full understanding of all the points listed and understood.

Client Name...

Signature………………………………………………………… Date………………………………………………

Permanent Makeup Technician Name………………………………………………………

Signature………………………………………………………………… Date…………………………………………

For re-touch procedure only (please check)

My medical history did not change

My medical history did change

Please state what did change…………………………………………………………………………………

Date of re-touch procedure…………………..Signature…………………………….