Indianapolis Microblading

Client Medical History Form

Date:_____ Birth Date:_____

Name:_____ Address:_____

City:_____ State:_____ Zip:_____

Phone:_____ Email:_____

Emergency Contact:_____ Phone:_____

Do you presently have or previously had any of the following: (Circle YES or NO)

YES NO Currently Pregnant/Breastfeeding
YES NO History of MRSA
YES NO Diabetes, Last A1C:_____
YES NO Cold Sores/Fever Blisters
YES NO Hepatitis (A, B,C, D)
YES NO HIV
YES NO Taking Blood Thinners
YES NO Abnormal Heart Condition
YES NO Easy Bleeding
YES NO Allergies to metals, food, etc.
YES NO Drug Allergies
YES NO Thyroid Issues
YES NO Alopecia
YES NO Impaired vision, contacts/glasses
YES NO Limited Range of motion
YES NO Trichotillomania (hair pulling)
YES NO Previous tattoo
YES NO Previous permanent makeup (year_____)
YES NO Cancer (year_____)
YES NO Chemotherapy/Radiation (year_____)
YES NO High blood pressure
YES NO Over 18 years old

YES NO Keloid scars
YES NO Hormonal Therapy
YES NO Oily skin
YES NO Tan by booth or sun/spray tans
YES NO Currently wear eyelash extensions
YES NO Take antibiotics before dental work
YES NO Psoriasis
YES NO Eczema
YES NO Tumors/Growths/Cysts
YES NO Autoimmune Disorder
YES NO Alcoholism
YES NO Smoke
YES NO Drug use (what?_____, last used:_____)
YES NO Chemical Peel/Facials(last treatment_____)
YES NO Brow tinting (last treatment_____)
YES NO Accutane or acne treatment (last used_____)
YES NO Botox (last treatment_____)
YES NO Fillers/Restylane/Juvederm (last treatment_____)
YES NO Forehead/Brow lift (year_____)
YES NO Facelift (year_____)
YES NO Had removal done to a previous cosmetic tattoo
YES NO Blepharoplasty (Eyelid surgery) (year_____)

YES NO Do you use any skin care products that contain Retin-A, Glycolic Acid, or Alpha Hydroxyl
YES NO Past surgery (for what? _____, date_____)
YES NO Currently taking antibiotics or have a known infection
YES NO Allergic reaction to any meds such as Lidocaine, Tetracaine, Epinephrine, Dermacaine, Benzyl Alcohol, Carbopol, Lecithin, Propylene Glycol, Vitamin E Acetate, etc.
YES NO Any diseases or disorders not listed? Please list:_____

Please list all medications and supplements you are currently taking: _____

_____

*I agree that the above information is true and accurate to the best of my knowledge.

Signed_____ Date:_____ Touch Up Initial and Date:_____

 Color Boost Initial and Date:_____

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