LASTING IMAGE FACE & BODY

HEALTH HISTORY ASSESSMENT for PERMANENT MAKE UP

LAST NAME (Please Print) _____ FIRST NAME _____ DATE OF VISIT_____

ADDRESS _____ CITY_____ ST_____ ZIP _____

HOME PH _____ CELL PH _____ CARRIER _____

EMAIL: _____ BIRTHDATE _____ /_____ / _____

REFERRED BY ❑ INTERNET ❑ YELP ❑ PHONE BOOK ❑ PHYSICIAN ❑ FAMILY ❑ OTHER: _____

WHAT AREAS ARE YOU INTERESTED IN TODAY? _____ FUTURE? _____

CURRENT MEDICATIONS: *Are you currently using any of the following? (check all that apply)*

❑ Aspirin ❑ Hormones ❑ Blood Thinners ❑ Steroids ❑ Insulin

❑ Antibiotics ❑ Tranquilizers ❑ Cortisone ❑ Antidepressants ❑ Blood Pressure

CONDITIONS

❑ Cancer ❑ Anemia ❑ Dry Eyes ❑ Fainting ❑ Vision Problems ❑ Collagen Injection

❑ Glaucoma ❑ Migraines ❑ Artificial Joints ❑ Seizures ❑ Asthma ❑ Rheumatic Fever

❑ Lupus ❑ Aids -/+ ❑ Botox/Fillers ❑ Keloid Scars ❑ Hemophilia ❑ Sinus/Hay Fever/Allergies

❑ Hepatitis ❑ Diabetes ❑ Herpes ❑ Fever Blisters ❑ Alopecia ❑ Heart Valve Replacement

❑ Hyperthyroid ❑ Mental Disease ❑ Plastic Surgery ❑ Cold Sores ❑ Chemical Peel ❑ High Blood Pressure

❑ Heart Condition ❑ Blood Transfusion ❑ Currently Pregnant ❑ Considering Plastic Surgery?

Any conditions or drugs not listed? _____

ALLERGIES: ❑ Latex ❑ Sulpha ❑ Tetracaine ❑ Lidocaine ❑ Epinephrine Other: _____

VITAMINS OR HERBS *you are currently taking*: _____

SURGERIES: *Have you had facial, back, neck or chest surgery?* _____ *date:* _____

COMMENTS OR CONCERNS? _____

_____ _____

signature date

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NOTES:

❑ Procedure Day Checklist ❑ Health History ❑ Release/Consent ❑ Aftercare Instructions

❑ Before Photo ❑ After Photo ❑ Allergies ❑ Allergies? ❑ Client taking meds before lip procedure? _____

❑ Beauty Mark ❑ Areola ❑ Corrective ❑ Pigmentation _____

Pigment Mix _____ Tolerance: _____

Device _____ Needle _____ Anesthesia _____

Take Home Packet: ❑ Lip ❑ Brow ❑ Liner

Comments: _____

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