Client Health History: Permanent Makeup and Microblading Health History Intake

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home/Cell Phone: _____ Work: _____

Email: _____ Preferred Contact: Cell____ Work ____ Email _____

Emergency contact name: _____ Phone _____

Relationship to you: _____

Are you over the age of 18 years? Yes___ No___

SKIN TYPE: Review the skin types below, using the Fitzpatrick Scale, and check the one that best describes your skin. This information will be used by your technician to determine the most appropriate way to approach your treatment(s):

- ❏ I. Very fair skin; blonde or red hair; light-colored eyes; freckles common
- ❏ II. Fair skinned; light hair, light eyes
- ❏ III. Very common skin type; fair; eye and hair color vary
- ❏ IV. Mediterranean Caucasian skin; medium to heavy pigmentation
- ❏ V. Mideastern skin; rarely sun sensitive
- ❏ VI. Black skin; rarely sun sensitive

Are you of Asian heritage (Class V) and/or have a history of keloid scarring? ❏ Yes ❏ No

Please list the products you use regularly:

Facial Cleanser _____ Moisturizer _____

Toner _____ Serum _____

Scrubs _____ Sunscreen _____

Retinol _____ Glycolic Acid _____

Enzymes _____ Peptides or Growth Factors _____

Cosmetic History

How would you describe your skin? ___Normal ___Combination ___Oily ___Dry

Have you had microblading or permanent makeup in the past? Yes___ No___

If yes, what area(s) were treated? _____

Do you have any scars in or around the area to be treated? Yes____ No___

Are you prone to keloid or hypertrophic scarring? Yes____ No_____

Have you ever had any of the following injectables or implants?

Botox	Radiesse	Perlane	Collagen	Dysport
Juvederm	Restylane	Silicone	Sculptra	

Other: _____

Continued ⇨

If yes, when? _____ What body area(s)? _____

Have you had any other cosmetic surgeries/procedures? Yes ___ No___ If yes, when? _____

What body area(s)? _____

Have you used Accutane in the past year? Yes____ No____

Health History

Have you had chemotherapy in the past 6 months? Yes___ No_____

Do you have any of the following conditions:

___Alopecia ___Trichotillomania (compulsive pulling of body hair) ___Eczema ___Dermatitis

___Pregnancy and/or breastfeeding ___Autoimmune disease ___Herpes Simplex ___Diabetes

___History of stroke ___Heart disease and/or heart defects ___Hemophilia ___High blood pressure

Do you have any other health conditions not mentioned here? Yes___ No___ If yes, please list _____

_____

Do you have moles/skin growths in the area to be treated? Yes___ No___

Do you or have you had a piercing in the area to be treated? Yes____ No___

Have you ever had a reaction at the dentist or any other time from numbing? Yes___ No___

Do you have any allergies to medications, food, latex, topical products, and/or other substances?

Please list: _____

Have you consumed drugs or alcohol in the last 24 hours? Yes___ No___

Have you undergone surgery in the last 2 weeks? Yes___ No___

Please list all vitamins and supplements including herbal remedies you take regularly _____

_____

Please list all current medications including aspirin, ibuprofen, blood thinners, etc. you take regularly _____

_____

What are you hoping to accomplish through microblading? _____

_____

Is there anything else you would like us to know? _____

_____

I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the esthetician of my current medical or health conditions and to update this history. A current medical history is essential to execute appropriate treatment procedures.

Client Name (Printed) _____

Client Name (Signature) _____ Date: _____

Esthetician/Technician: _____ Date: _____