Medical History for Microblading Application

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| Full Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B:\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_\_ Zip Code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Emergency Contact Name & Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Please answer the following questions at your best knowledge:

Are you over the age of 18? Yes ( ) No ( )

Are you pregnant or breast feeding? Yes ( ) No ( )

Do you have history of hemophilia or excessive bleeding? Yes ( ) No ( )

History of skin disease, skin lesions, or skin sensitivities to soaps or disinfectants?

Yes ( ) No ( ) If yes, specify:

History of epilepsy, seizures, fainting or narcolepsy? Yes ( ) No ( )

Have you ever had treatment with anticoagulants or medications that thin the blood and/or interfere with blood clotting? Yes ( ) No ( )

Are you currently or have you ever used RETIN A, RENOVA, LASH GROTWTH product, Hydroxyl (Glycolic) Acid or Accutane? Yes ( ) No ( )

If yes, name product and last dose:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have diabetes? Yes ( ) No ( )

If yes, specify:

Do you have allergies to anesthetics? Yes ( ) No ( )

If yes, specify:

Do you have any serious medical condition? Yes ( ) No ( )

Have you ever been tested positive for HIV or Hepatitis? Yes ( ) No ( )

Any other information that would aid your procedure? Yes ( ) No ( )

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_

Artist Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_