**Confidential Medical Profile - Micropigmentation**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**To Avoid Unforeseen Complications, Please Answer The Following Questions**

|  |  |
| --- | --- |
| Are you under 18? □yes □ noIf so, guardians initials\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | Are you allergic to any metal? □yes □ no |
| Have you had any aspirin or blood thinners in the past week? □yes □ no | Have you ever had any semi-permanent makeup procedures before? □yes □ no |
| Any mood altering drugs within the last 8 hours? □yes □ no  | Are you on any immunosuppressive medications such anti-inflammatories or steroids? □yes □ no  |
| Do you have a history of cold sores, herpes, or fever blisters? □yes □ no | Are you allergic to topical antibiotic preparations or desensitizers? □yes □ no  |
| Are you sensitive/allergic to latex? □yes □ no  | Is there any history of skin diseases or remarkable skin sensitivities? □yes □ no  |
| Have you had a chemical peel or laser?□ yes □ noIf so, when?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | Are you currently taking any vitamins a or e in any form? □yes □ no  |
| Do you have problems healing? □yes □ no | Are you pregnant or nursing? □yes □ no |
| Are you currently undergoing radiation or chemotherapy? □yes □ no | Are you required to take antibiotics during dental or invasive medical procedures? □yes □ no |
| Are you currently using any retin-a or alpha-hydroxy skin care products? □yes □ no | Do you wear contact lenses?(if yes i understand they must be removed during my eyeliner procedure and should not be replaced until the next day) □yes □ no  |
| Previous problems with tattoos or has your physician advised you not to have a tattoo at this time? □yes □ no |  |

List all medications you are currently taking:

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**Please Circle Any Of The Following Which May Pertain To You**

|  |  |  |  |
| --- | --- | --- | --- |
| **Heart Conditions** | **Allergies To Makeup** | **Accutane Treatment** | **Dry Eyes** |
| **Diabetes** | **Stroke** | **Chest Pains** | **Alopecia** |
| **Refractive Eye Surgery** | **Glaucoma** | **Trichotillomania** | **Keloid/Hypertrophy Of Scars** |
| **Epilepsy/Seizures** | **Shortness Of Breath** | **Autoimmune Disorder** | **Cancer (Any)** |
| **Hepatitis/ Jaundice** | **Hiv** | **Kidney Disease** | **Tendency To Develop Fever** |
| **Blisters On The Lip** | **Ocular Herpes** | **Hyperpigmentation** | **Hypopigmentation** |
| **Tendency To Bleed Excessively From Minor Injuries** |  |  |  |

List any other medical conditions or issues not addressed above:

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Primary Physician’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Physician’s Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By signing below, I acknowledge, understand and agree that:

* the staff at Shade Raleigh PMU do not practice medicine, does not accept health insurance, and have made no representation to the contrary;
* the information provided on this form is accurate and complete to the best of my knowledge, and that Shade Raleigh PMU is not responsible for complications or problems arising from any incorrect or omitted information;
* some individuals will have complications related to semi-permanent makeup application. These complications are usually mild and last only a few days. However, extreme complications are always a possibility. I accept these risks and agree to hold Shade Raleigh PMU and its employees and contractors harmless for same;
* the staff at Shade Raleigh PMU will use the information provided above to assess my suitability for the proposed micropigmentation services.

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Client signature (or guardian if under 18 years of age) Date