ideally brows
permanent cosmetic studio

CLIENT HISTORY

Please print clearly

Today's Date: _____

Name: _____ Date of Birth: _____

Address: _____
Street City State Zip

Home Phone:_____ Cell Phone: _____

Email Address: _____ Referred by: _____

Ethnic Background (include all nationalities)_____

Emergency Contact Name:_____Phone Number:_____

ALLERGIES: Check if you have ever had an allergic reaction to any of the following and described what happened below.

□ Latex rubber □ Tattoo ink/pigment □ Novocain, Lidocaine □ Benzocaine, Tetracaine

□ Lanolin □ Bacitracin Ointment □ Neomycin or polymyxin B ointment

□ PABA □ Metal(s)

□ Foods: _____

Other allergies: _____

Reaction: _____

EYES/EYEBROWS: Check all of the following that apply.

□ Contact lenses □ Dry eyes □ Eye makeup sensitivities □ Blurred Vision

□ Glaucoma □ Lasik /eye surgery □ Thyroid abnormalities □ Alopecia Areata (local)

□ Alopecia Universalis (total) □ Pull out lashes/eyebrow compulsively (Trichotillomania)

□ Other hair loss (describe): _____

□ Eyebrow/Lash tinting
Date of last service: _____

□ Botox
Date of last service:_____

Other eye disorders:_____

LIPS: Check all of the following that apply.

□ Cold sores/fever blisters/herpes. If yes, an antiviral prescription is required prior to any lip procedure.

□ Lip injections - Type: _____ Date: _____

□ Other lip augmentation - Type: _____ Date: _____

SKIN: Check all of the following that apply.

□ Any other tattoos - Location: _____
Age of tattoo: _____ Any problems: _____

□ Use of sunlamp/tanning bed/suntan outdoors □ Currently tanned in the area being treated.

□ Currently use Retin A - Location: _____ □ Currently using glycolic acid, AHA or Retinol?

□ Injectables such as Restylane, Juvederm or other fillers? _____

□ Ever had a chemical peel? When:_____ □ Type of peel:_____

□ Do you have a scar you want camouflaged? Age of Scar: _____

□ Any keloid or hypertrophic scars? - Location: _____

□ Do you bruise or bleed easily? □ Do you have healing problems?

□ Other active skin disorders? Describe: _____

_____

GENERAL MEDICAL: Check all of the following that apply.

□ Diabetes □ Heart Palpitations

□ High blood pressure □ Mitral valve prolapse or valve implants

□ Pregnant or nursing □ Hemophilia or other clotting disorders

□ Taken Accutane within the last 6 months

□ Currently on blood thinners or anticoagulants such as Coumadin, aspirin, ibuprofin, alcohol? _____

□ Autoimmune disorders - describe: _____

□ Do you have a condition such as Hepatitis, HIV or undergoing treatment such as chemotherapy that could affect healing?

_____

□ Seizures - describe: _____

□ Current use of controlled substances - describe: _____

Please list any surgeries: _____

If you are planning cosmetic or other surgeries/procedures in the near future, describe: _____

_____

List all medications, prescription and non-prescription that you have taken in the last two weeks: _____

_____

If you are currently under a physician's care for any condition, describe: _____

Physician's Name: _____City: _____ Phone: _____

This history has been reviewed by the technician and my questions have been satisfactorily answered. I have also received and reviewed a copy of the After Care Instructions and products. I understand them and agree to follow them.

Signature: _____ Date: _____