

**Confidential Medical Profile - Microblading**

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

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

# To Avoid Unforeseen Complications, Please Answer The Following Questions

|  |  |
| --- | --- |
| Are you under 18? □yes □ no  If 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 □ no If 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:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

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

* the staff at Fortees Salon & Spa 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 Fortees Salon & Spa 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 Fortees Salon & Spa and its employees and contractors harmless for same;
* the staff at Fortees Salon & Spa will use the information provided above to assess my suitability for the proposed micropigmentation services.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

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

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5865 w. Ray road ste.1 chandler, az 85226 | 480.753.4765 | www.forteessalon.com