Medical History Form

Custom Beaute

Permanent Cosmetics

Client Name:	Date:	Female / Male:	DOB:
Address:	City:	State:	Zip:
Occupation:	Cell Phone:	Home Phone:	
Email Address:	Physicians Name:	Physicians Phone:	

A "yes" answer below does not necessarily indicate that you are not an acceptable candidate for permanent cosmetics. It may simply be information that is valuable to me as your technician as each person's body is unique. It may also indicate that based on any health conditions healing may be affected or you may be required to consult with your physician before proceeding.

Question	Yes	No
Are you pregnant or nursing?	Yes ☐	No ☐
Have you had any alcohol in the last 24 hours?	Yes ☐	No ☐
Have you ever had cold sores or fever blisters?	Yes ☐	No ☐
Do you have any allergies to latex?	Yes ☐	No ☐
Have you had a laser or chemical peel within 6 months?	Yes ☐	No ☐
Have you ever had any permanent cosmetics or tattoos applied?	Yes ☐	No ☐
Do you bruise easily?	Yes ☐	No ☐
Do you routinely use Retin-A, Accutane, glycolic, or other exfoliating products?	Yes ☐	No ☐
Do you wear contact lenses?	Yes ☐	No ☐
Are you allergic or sensitive to any metals, for instance, metals used for jewelry?	Yes ☐	No ☐
Do you have any problems healing from small wounds?	Yes ☐	No ☐
Is your skin oily?	Yes ☐	No ☐
Do you use tobacco? If you use tobacco you may heal slower.	Yes ☐	No ☐
Do you have any heart conditions?	Yes ☐	No ☐
Are you diabetic? If so, Type 1 or Type 2?	Yes ☐	No ☐
Do you have any autoimmune disorders?	Yes ☐	No ☐
Are you sensitive or allergic to hand creams or body lotions?	Yes ☐	No ☐
Do you have your lips injected with filler materials?	Yes ☐	No ☐
When is your next menstrual date (if applicable)?		
Do you hyper-pigment (tendency to develop dark spots on the skin from wounds or sun).	Yes ☐	No ☐
Do you hypo-pigment (lack of pigment in the skin)?	Yes ☐	No ☐
Do you tend to develop keloid or hypertrophy scars?	Yes ☐	No ☐
Do you scar easily from minor skin injuries?	Yes ☐	No ☐
Do you have any seizure related conditions?	Yes ☐	No ☐
Do you have a tendency to faint or become dizzy?	Yes ☐	No ☐
Do you bleed excessively from minor cuts?	Yes ☐	No ☐
Do you have prosthetic implants?	Yes ☐	No ☐
Do you consume aspirin daily?	Yes ☐	No ☐
Are you under treatment for depression	Yes ☐	No ☐
Are you sensitive to petroleum-based products?	Yes ☐	No ☐
Do you have Botox injections?	Yes ☐	No ☐
If you have permanent cosmetics or tattoos did you have any problems with healing	Yes ☐	No ☐

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after they were applied?		
Are you undergoing radiation or chemotherapy treatment?	Yes ☐	No ☐
Are you wearing a pacemaker?	Yes ☐	No ☐
List any prescription drugs you are currently taking.		
Do you have a history of skin sensitivities?	Yes ☐	No ☐
Do you have any medical condition that has resulted in a medical professional requiring you to pre-medicate with an antibiotic prior to a dental or other invasive procedure?	Yes ☐	No ☐
Do you have allergies to topical makeup?	Yes ☐	No ☐
Do you have dry eyes?	Yes ☐	No ☐
Do you intentionally tan – direct sun or tanning bed?	Yes ☐	No ☐
Do you personally have any history of cancer?	Yes ☐	No ☐
Do you have a history of stroke or heart attack?	Yes ☐	No ☐
Do you have problems being anesthetized for dental procedures?	Yes ☐	No ☐
Do you have glaucoma or any other eye disease?	Yes ☐	No ☐
Do you have arthritis?	Yes ☐	No ☐
Do you have high or low blood pressure?	Yes ☐	No ☐
Do you have sinus problems?	Yes ☐	No ☐
Do you have any type of hepatitis?	Yes ☐	No ☐

If you answered “Yes” to any of these questions, please provide us with any additional explanations.

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Client Name: ______________________________

Client Signature: ______________________________

Date: ______________________________

Technician Signature: ______________________________

Date: ______________________________

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