



## Brow Me Pretty

### Semi-Permanent Makeup Health History Form

Semi-Permanent Cosmetics (tattooing), Microblading | Nano-Blading | HyperRealistic Brows are invasive procedures that requires a thorough medical history. Please complete this questionnaire.

Name \_\_\_\_\_ Age \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_

Telephone # \_\_\_\_\_ Email \_\_\_\_\_

Emergency contact \_\_\_\_\_ Telephone # \_\_\_\_\_

Are you currently under the care of a physician? If so, why? \_\_\_\_\_

**Do you have allergies to Lidocaine products?** \_\_\_\_\_ Yes \_\_\_\_\_ No

Have you had any previous permanent makeup procedure? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please specify: \_\_\_\_\_

Are you pregnant or breast feeding? \_\_\_\_\_ Yes \_\_\_\_\_ No

**Have you used Accutane within the last 6 months?** \_\_\_\_\_ Yes \_\_\_\_\_ No

#### **Important\*\*\*PLEASE LIST ALL ALLERGIES:**

---

---

**It is Red Cross policy that you cannot donate blood for one year from date of this procedure. If you have had hepatitis in the last 12 months you cannot have this procedure.**

<b><u>Skin Condition/Treatments</u></b>	<b><u>Medications</u></b>	<b><u>Current Health Conditions</u></b>
<input type="checkbox"/> Skin Cancer *	<input type="checkbox"/> Anti-Depressants* 50/50	<input type="checkbox"/> Good <input type="checkbox"/> Poor
<input type="checkbox"/> Moles* - <input type="checkbox"/> Rosacea*	<input type="checkbox"/> Chemotherapy* Dr. Perm	<input type="checkbox"/> Alopecia
<input type="checkbox"/> Psoriasis*	<input type="checkbox"/> Radiation*area _____	<input type="checkbox"/> Heart Problems
<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Heals Normal - <input type="checkbox"/> Delayed	<input type="checkbox"/> Blood Thinners*over 1mg	<input type="checkbox"/> Pregnant/Nursing*
<input type="checkbox"/> Use Retin A	<input type="checkbox"/> Pain Pills/Shots/steroids	<input type="checkbox"/> Cancer*
<input type="checkbox"/> Chemical Peel* 6w	<input type="checkbox"/> Tranquilizers*	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Cortisone Creams*	<input type="checkbox"/> Insulin*	<input type="checkbox"/> HIV Virus
<input type="checkbox"/> Scars* - <input type="checkbox"/> Keloids*	<input type="checkbox"/> Anti-Herpes Med	<input type="checkbox"/> Lupus*
<input type="checkbox"/> Laser Therapy* 6w	<input type="checkbox"/> Vit E/ Fish Oil	<input type="checkbox"/> Diabetes*
<input type="checkbox"/> Tattoo Removal	<input type="checkbox"/> Hormone Therapy HRT/RT	<input type="checkbox"/> Alcohol/Drug Abuse*
<input type="checkbox"/> Cosmetic Surgery within 6M		<input type="checkbox"/> Seizures/Dizziness*

#### **Any other prescription medications or conditions not listed?**

---

---

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_