

CLIENT CONSULTATION AND MEDICAL HEALTH FORM FOR MICROBLADING

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_ Best Phone Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ List any medications you have been taking in the past 6 months:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Have you received chemotherapy or radiation in the past year?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Have you ever had an allergic reaction to any of the following (please circle):**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Latex | Lanolin | Vaseline | Medications | Metals |
| Hair Dyes | Foods | Lidocaine | Paints | Crayons /Glycerin |

**Have you ever had a cold sore?** Yes No

If yes, you must contact your physician for a preventative prescription capsule to prevent a cold sore.

**Have you ever had one of the following (please circle):**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Retin-A in last 2 weeks | Anemia | Sensitivity to cosmetics | Prolonged bleeding | Diabetes |
| Epilepsy | Artificial Heart Valve | Low Blood Pressure | High Blood Pressure | Haemophilia |
| Fainting Spells | Dizziness | Circulatory Problems | Hypertrophic scars | Liver Disease |
| Growths | Cysts | Botox/Fillers | Chemicial/Laser Peel | Thyroid disturbance |
| Keloid Scars | Healing proplems | AHA in last 2 weeks | Hair Loss | Hepatitis |
| Bruise/Bleed easily | Pregnant or nursing | Trichotiloma | HIV | Alopecia Tumours |
| Do you scar easily? |  |  |  |  |

**What are the main concerns relating to your eyebrows?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What would you like to improve about your eyebrows?** Consider shape, color, density, thickness…

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**For therapist use** – Note pigments, blades, techniques used for this client

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**Are you currently under the care of a physician? If yes, please explain**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Physician’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you take antibiotics when going to the dentist?** \_\_\_\_\_\_\_\_\_If yes, why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Are you currently taking medication that thins the blood?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please read the following statements carefully.** Microblading is a way of cosmetic tattooing, re-touch procedures may be required. A healing period of 4-6 weeks is required before a touch up procedure can be performed. On a rare occasion, the pigment may migrate under the skin. Procedure of microblading may be slightly uncomfortable. The pigments will fade. Immediately after the procedure, the pigment can appear 30-50% darker than the desired result. Although extremely rare, there might be an immediate or delayed allergic reaction to pigment. A negative patch test result does not guarantee that you will not develop an allergic reaction after the full procedure. Allergic reactions to anesthetic can occur. Permanent cosmetics cannot be applied if you are pregnant or nursing, or anyone under the age of 18. Infections can occur if aftercare instructions are not followed correctly. There may be swelling and redness following the procedure. You may experience minor bleeding. If you have an MRI scan within 3 months after microblading procedure, you should notify/discuss with your doctor. Possible scarring may occur, but is extremely rare.

**I have received after care information and I’m fully aware of the after care procedures**. Yes No

I fully understand the information provided above & confirm that all info provided by me is correct and truthful.

Client’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client’s signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_

Technician’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Technician’s signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_