FringeBrow

CLIENT HISTORY

Name:_____ Date of Birth: _____

Address:_____
Street City State Zip

Home Phone:_____ Business Phone:_____

Cell Phone:_____ May we contact you at these numbers:_____

Email Address:_____ Other ID:_____

Referred By:_____

Emergency Contact:_____

PROCEDURE(S) DESIRED: Check all of the following that apply.

☐ ☐Full Eyebrows

_____

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 ☐Novovaine, Lidocaine
☐ Benzocaint, Tetracaine ☐Lanolin ☐Bacitracin Ointment
☐ Neomycin or polymyxin B Ointment ☐ PABA ☐ Metals(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)
☐ Other hair loss (describe): _____
☐Eyebrow/Lash Tinting ☐Botox:
Date of last Service:_____ 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 augmentations - Type _____ Date: _____

☐ Teeth Bleaching – Date: _____

SKIN: Check all the following that apply:

☐Any other tattoos – Location: _____

Age of Tattoo:_____ Any problems:_____

☐ Use of sunlamp/tanning/suntan outdoors ☐ Currently tanned in the are being treated

☐Currently use Retin A – Location:_____

☐Currently using glycolic Acid, AHA, or Retinol or other filler?_____

☐Ever had a chemical peel? _____ ☐ 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 ☐Pregnant or nursing

☐Mitral valve prolapse or valve implants ☐ Hemophilia

☐ Taken Accutane within the last 6 months

☐ Are you Currently on Blood thinners or anticoagulants such as Coumadin, aspirin, ibuprofin, alcohol?

☐ Autoimmune disorder- describe: _____

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

☐ Seizures – Describe: _____

☐ Current use of controlled substances: _____

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:_____

The history of this profile has been reviewed by the technician, and my questions has been satisfactorily answered. I have also received and reviewed a copy of the Pre-Procedure Information Sheet and the Aftercare Sheet. I understand them and agree to follow them.

Signature:_____ Date: _____