Permanent Make-Up and Corrective Cosmetics
Client Questionaire

Name			
Birth Date	Day	Month	Year
E-Mail			
Phone			
Referred By			
Procedures			

Do you wear contact lenses? NO____YES____
If YES, they must be removed and should not be replaced until next day, please use eyeglasses.

Are you allergic to anesthetics? NO____YES ____ Which ones?________________________________

Have you had surgeries around the eyes? NO____YES____ When?______________________________

Do you have allergies? NO____YES____What kind?____

Do you have Tatoo? NO____YES____ Are you Pregnant? NO____YES____

Do you have any type hearth condition? NO____YES____Please specify_________________________

Are you diabetic? NO____YES____

Do you bruise easily? NO____YES____

Do you have any serious medical condition?____

Have you ever tested for HIV ar Hepatitis?____

Are you presently taking any medications, including immunosupressive such as anti-infammatory or steroids? NO____YES____ Specify____

Are you able to take over the counter antihistamine (Benadryl) NO____YES____

Does your skin swell very easily? NO____YES____

Are you allergic to topical antibiotic preparations, ie Polysporin, Baciytacyn or Neosporin?
NO____YES____Specify____

Client initials_____________ **Technician Initials**______________

Do you use Retin A or Hydroxyl (Glycolic) Acid? NO____YES____
These products will fade tattoed area.

Have you ever had a fever blister, cold sore or canker sore? NO____YES____

Do we require a physicians note?NO____YES____

Understand Physicians Notes must be on their letterhead or prescription pad.

Are there any other areas or concerns not mentioned? ____

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________________________________ Client

________________________________ Technician

________________________________ Date

	Fee Schedule	Amount
Consultation		
Eyebrows		
Lower Eyeliner		
Upper Eyeliner		
Lip Liner		
Full Lip Shading		
Other		