Client Health History Form

Name: _____

DOB: _____

Date: _____

How did you hear about Zapps? _____

Is this your first permanent make-up experience?

☐ **Yes** ☐ **No**

If No, what kind of permanent make-up did you have?

☐ **Microblading** ☐ **Eyeliner** ☐ **Lip Blushing**

Are you currently wearing lash extensions of any kind?

☐ **Yes** ☐ **No**

HAVE YOU EVER HAD AN ALLERGIC REACTION TO ANY OF THE FOLLOWING (PLEASE CHECK)

☐ LATEX
☐ LANOLIN
☐ ANAESTHETICS
☐ VASELINE
☐ MEDICATIONS
☐ ADRENALIN
☐ LIDOCAINE
☐ PAINTS
☐ FOODS
☐ METALS
☐ HAIR DYES
☐ CRAYONS

*OTHER ALLERGIES*_____

_____

Contraindications for Permanent Make-up (check if applicable):

☐ Liver disease-high risk of infection
☐ Preg nancy/Nursing
☐ Compromised skin near brow/eye area
☐ Chemotherapy/Radiation
☐ Skin conditions like psoriasis, dermatitis, active herpes oubreak, etc... near the brow/eye area
☐ Retinoid/AHA/BHA within the last 2 weeks
☐ Blood thinning medications/substances or plasma donation within the last 7 days

The following medical conditions require a note from your doctor giving consent (check if applicable):

☐ Diabetes Type 1 and 2
☐ High Blood Pressure
☐ Auto-immune Disease
☐ Thyroid/Graves' Disease
☐ Any other medical condition that causes slow healing or a risk of infection

Do you have or have you ever had any of the following conditions? Check all that apply:

- ☐ Abnormal Heart Condition
- ☐ Mitral Valve Prolapse
- ☐ Rheumatic Fever
- ☐ Pacemaker
- ☐ Hemophilia
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting Spells or Dizziness
- ☐ Thyroid Disturbances
- ☐ Glaucoma
- ☐ Stomach Ulcers
- ☐ Cancer
- ☐ Tuberculosis
- ☐ Stroke
- ☐ Palpitations
- ☐ Hepatitis
- ☐ Pregnant or Nursing in the last 12 months
- ☐ Alopecia
- ☐ Recent Hair Loss
- ☐ Chapped Lips
- ☐ Trichotillomania
- ☐ Cold Sores (herpes simplex)
- ☐ Heart Murmur
- ☐ Artificial Heart Valves
- ☐ Anemia
- ☐ Prolonged Bleeding
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Circulatory Problems
- ☐ Liver Disease
- ☐ Kidney Disease
- ☐ Tumors, Growths or cysts
- ☐ HIV
- ☐ Prosthetic Hip or Joint
- ☐ Cataracts
- ☐ Blurred Vision
- ☐ Dry Eyes
- ☐ Eye Infection Present
- ☐ Watery Eyes
- ☐ Contact Lenses
- ☐ Eyelid Surgury
- ☐ Date of last eyelash/brow tint_____

What would you like to improve about your eyebrows or lips? *Consider shape, color, density, thickness...*_____
_____.

Please read the following statements carefully. Permanent makeup is a way of cosmetic tattooing, intended to be semi-permanent, lasting an average of 12-18 months. On a rare occasion, the pigment may migrate under the skin. The procedure of permanent makeup may be uncomfortable. 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 performed 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 and brusing.. If you have an MRI scan within 3 months after your procedure, you should notify/discuss with your doctor. Possible scarring and inconsistency of color may occur.

The information I have provided about my medical history is accurate to the best of my knowledge. I agree to accept responsiblity for omissions regarding my failure to disclose any existing or past health conditions.

Date:_____

Client name (printed):_____

Client Signature: _____

Therapist Signature:_____