Permanent Cosmetic Make-up Medical Information

Please answer all questions and bring this form with you to your first appointment.

Name: _____ MR# _____ Date: _____

		Yes	No
1	Have you ever had Permanent Cosmetic make-up before? When? _____		
2	Are you pregnant or nursing?		
3	Are you on a blood thinning medication?		
4	Do you take aspirin regularly?		
5	Do you smoke?		
6	Do you drink alcohol?		
7	Are you on Accutane, or have you taken it within the last year?		
8	Do you have Mitral Valve Prolapse?		
9	Prior to dental procedures, do you receive antibiotic therapy?		
10	Are you on steroids or anti-inflammatory medications?		
11	Have you had an organ transplant?		
12	Are you an insulin diabetic?		
13	Do you have seizures or fainting spells?		
14	Do you bruise or bleed easily?		
15	Do you swell easily?		
16	Do you have a healing problem?		
17	Do you have keloids? Do your scars heal in a raised manner or darker color?		
18	Do you use Retin-A, Glycolic Acid, Vitamin C or any other exfoliants?		
	Please answer the following questions for Eyeliner procedure		
19	Do you wear contact lenses?		
20	Do you have glaucoma or other eye disease or disorder?		
21	Have you ever had an eye trauma?		
22	Have you had a vision correction procedure such as RK or LASIK surgery in the last 3 months?		
23	Are you considering having vision correction procedures in the next 2 months?		
24	Are you prone to eye infections (i.e., conjunctivitis/pink eye)?		