

# MEDICAL PROFILE & CONSENT FORMS FOR PERMANENT MAKEUP

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

Street

City

State

Zip Code

Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Referred By \_\_\_\_\_

## To avoid unforeseen complications, please answer the following questions:

- Yes  No Are you under the age of 18? Legal guardian's initials: \_\_\_\_\_
- Yes  No Have you had any alcohol, aspirin or blood thinning products within the last 7 days?
- Yes  No Have you had any mood altering drugs within the last 8 hours?
- Yes  No Do you have any history of cold sores, herpes, or fever blisters?
- Yes  No Are you sensitive to Latex?
- Yes  No Have you ever had a reaction to products with a petroleum base? (e.g. Aquaphor, A & D Ointment)
- Yes  No Have you had botox, lip fillers, chemical or laser peel? If so, when? \_\_\_\_\_
- Yes  No Do you have problems with healing?
- Yes  No Have you had previous problems with tattoos or has your physician advised you not to have a tattoo at this time?
- Yes  No Are you currently undergoing radiation or chemotherapy?
- Yes  No Are you currently using Retin-A or "Alpha Hydroxy" skin care products?
- Yes  No Do you wear contact lenses?  
(if yes, I understand they must be removed before my eyeliner procedure and should not be replaced until the next day.)
- Yes  No Do you wear a pacemaker?
- Yes  No Are you allergic to any metal? (e.g. you can only wear 14K gold)
- Yes  No Have you ever had any permanent make-up procedures before?
- Yes  No Is your skin excessively oily?
- Yes  No Are you presently taking any medication, including immunosuppressive, such as anti-inflammatory or steroids?
- Yes  No Do you have ill effects from withdrawal from caffeine products?
- Yes  No Are you allergic to topical antibiotic preparations or numbing desensitizers?  
(e.g. Polysporin, Bacitracin, Neosporin, or "Caine" family of drugs)
- Yes  No Is there any history of skin diseases or remarkable skin sensitivities?
- Yes  No Are you presently taking Vitamins A and/or E in any form?
- Yes  No Are you pregnant or nursing?
- Yes  No Do you use tobacco?
- Yes  No Are you required to take antibiotics during dental or invasive medical procedures?

## Please check any of the following which pertain to you:

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Heart conditions            | <input type="checkbox"/> Epilepsy/seizures of any kind | <input type="checkbox"/> Prone to gagging                                  | <input type="checkbox"/> Hyper-pigmentation (darkening of the skin) |
| <input type="checkbox"/> Allergies to makeup         | <input type="checkbox"/> Autoimmune disorders          | <input type="checkbox"/> Hepatitis/jaundice                                | <input type="checkbox"/> Aspirin consumption                        |
| <input type="checkbox"/> Accutane treatment          | <input type="checkbox"/> Anemia                        | <input type="checkbox"/> Gore-Tex implants                                 | <input type="checkbox"/> Hypo-pigmentation (lightening of the skin) |
| <input type="checkbox"/> Dry eyes                    | <input type="checkbox"/> Arthritis                     | <input type="checkbox"/> Kidney disease                                    | <input type="checkbox"/> High blood Pressure                        |
| <input type="checkbox"/> Menstrual cycle             | <input type="checkbox"/> Arthritis                     | <input type="checkbox"/> Fainting or black-out spells                      | <input type="checkbox"/> Low blood Pressure                         |
| <input type="checkbox"/> Keloid or hypertrophy scars | <input type="checkbox"/> Head injuries                 | <input type="checkbox"/> Tendency to develop fever blisters on the lip     | <input type="checkbox"/> Ocular herpes                              |
| <input type="checkbox"/> Diabetes                    | <input type="checkbox"/> Glaucoma                      | <input type="checkbox"/> Tendency to bleed excessively from minor injuries | <input type="checkbox"/> Neck/back pain                             |
| <input type="checkbox"/> Stroke                      | <input type="checkbox"/> Sinus problems                | <input type="checkbox"/> Tendency to scar from minor skin injuries         | <input type="checkbox"/> Other medical conditions (explain below)   |
| <input type="checkbox"/> Shortness of breath         | <input type="checkbox"/> Migraines headaches           | <input type="checkbox"/> Chronic coughing                                  |   |
| <input type="checkbox"/> Alopecia                    | <input type="checkbox"/> Trichotillomania              |  |   |
|  | <input type="checkbox"/> Prosthetic implants           |  |   |
|  | <input type="checkbox"/> Cancer (any type)             |  |   |

Please explain if any of the answers to the first section were answered YES or if any of the conditions in the second section were checked as pertaining to you. Use the reverse side of this form if additional space is required.

Practitioner makes no attempt to, or claim to, practice medicine. Some individuals will have complications related to permanent make-up application. These complications are usually mild and last only a few days. However, extreme complications are always a possibility. If you are healthy and there are no visible reasons restricting you from receiving a tattoo, you must approve of the design and color before the application of your permanent make-up.

Client's Signature

Date

# INFORMED CONSENT FOR PERMANENT MAKEUP

The nature and method of the proposed Permanent Make-up (tattoo) procedure has been explained to me as have the usual risks inherent in the procedure and the possibility of complications during and following its performance. I understand there may be a certain amount of discomfort or pain associated with the procedure and that other adverse side effects may include minor and temporary bleeding, bruising, redness or other discoloration and swelling; fever blisters may occur on the lips following lip procedures in individuals prone to this problem. Fading or loss of pigment may occur. Secondary infection in the area of the procedure may occur, however, if properly cared for, is rare.

I, \_\_\_\_\_ acknowledge by signing below, that I have been given the full opportunity to ask any and all questions which I might have about obtaining of any permanent cosmetic procedures at Dermaluxe Spa. I also acknowledge that all of my questions have been answered to my full and total satisfaction. I specifically acknowledge that I have been advised of the fact and matters set below, and I agree as follows:

- I acknowledge that it is not reasonably possible to determine whether I might have an allergic reaction to any of the pigments, dyes, topical preparations, or processes used in the procedure; and I agree to accept the risk that such a reaction is possible.  
I have informed the practitioner of any existing problems. \_\_\_\_\_ (initial)
- I acknowledge that complications are always possible as a result of the permanent make-up procedure, particularly in the event that post-procedural (after care) instructions are not followed. \_\_\_\_\_ (initial)
- I acknowledge that hyper-pigmentation (darkening of the skin), hypo-pigmentation (the absence of color in the skin), or scarring is a possibility as a result of my body's reaction to the skin being broken during this procedure. I realize that my body is unique and the practitioner or any of the practitioners associates cannot predict how my skin may react as a result of the procedure. \_\_\_\_\_ (initial)
- I acknowledge that the procedure will result in a permanent change to my appearance and that no representations have been made to me as to the ability to later change or remove the result. \_\_\_\_\_ (initial)
- I understand that future laser treatments or other skin altering procedures, such as plastic surgery, implants, and/or injections may alter and degrade my permanent make-up. I further understand that such changes are not the fault of the practitioner and/or any of the practitioners associates. I further understand that such changes in my appearance may not be correctable through further Permanent Make-up procedures. \_\_\_\_\_ (initial)
- I am aware that cosmetic tattooing is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of the procedure. \_\_\_\_\_ (initial)
- I authorize the practitioner and/or any of the practitioners associates to obtain per-procedural and post-procedural photographs, and give them permission to use such photographs for publication and/or teaching purposes as they choose. \_\_\_\_\_ (initial)
- For the purposes of education or assistance, I consent to the admittance of authorized observers to the procedure(s). \_\_\_\_\_ (initial)
- I acknowledge that the obtaining of Permanent Make-up procedure(s) is by my choice alone, and I consent to the application of the procedure and to its attendant risks, and to any actions or conduct of the practitioner and/or any of the practitioners associates reasonably necessary to perform the procedure(s). \_\_\_\_\_ (initial)
- I have had the patch test procedure explained to me. I do/I do not (*circle your choice*) choose to have the patch test. The choice releases the practitioner and/or any of the practitioners associates from any liability related to any allergic or other reaction to applied pigments.  
\_\_\_\_\_ (initial)
- I am aware that the Herpes Simples 1 and the Papilloma Viruses may manifest with the lip procedure due to trauma to the lip tissue. Herpes Simples 1 Virus is normally treated with anti-viral medications, some of which are available by prescription only. \_\_\_\_\_ (initial)

- The fee for services has been explained to me and is satisfactory. I understand the total fee for services rendered is due upon completion of the initial procedure and that there will be separate fees for any necessary modification of pigment color or shape (outside of initial procedure and one or two follow-up appointments) depending of the procedures. Because Permanent Make-up is a service, the practitioner employs a no refund policy. For many skin types, Permanent Make-up may be a multi- step process. I must schedule the follow-up visit no sooner than four weeks after each procedure. Subsequent visits will be subject to an additional fee. \_\_\_\_\_ (initial)

I have read and understand the contents of each paragraph above. I acknowledge this is a contract and that I have received no warranties or guarantees. I further acknowledge that at the time of signing this consent to this procedure(s), I was of sound mind and capable of making independent decisions for myself. \_\_\_\_\_ (initial)

\_\_\_\_\_  
Clients signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Practitioners signature

\_\_\_\_\_  
Date