

CLIENT INFORMATION SHEET

NAME _____ Date of Birth: _____

ADDRESS _____

PHONE (Day) _____ Night _____

May we contact you at these numbers if necessary? Yes No

PROCEDURES DESIRED:

Eyeliner Eyebrows Lipline Full Lip Color Nipples
 Beauty Mark Skin Repigmentation Other _____

If you selected "other" please explain: _____

Have you **ever** had a herpes or cold sore? Yes No If yes, contact your physician for a prescription of ZOVIRAX or some other anti-viral medication.

I have read the above information regarding an anti-viral and understand its use is mandatory if I desire lipline or full lip color procedures.

*Signed: _____ (Client)

Who referred you: _____

Are you currently under the care of a physician? Yes No

If so, why? _____

Physician's name: _____

Do you take antibiotics when going to the dentist? Yes No If Yes, Why? _____

Do you suffer from: Allergies Moles or freckles at site of tattoo Hepatitis

Heart Problems Hemophilia Diabetes Skin Problems Scarring (Keloids)

Eye Problems Epilepsy Other: Please explain: _____

Are you presently taking any medication which thins the blood? Yes No

Are you taking other medications including anti-depression or mood altering drugs? Yes No

If yes, explain: _____

Are you pregnant or nursing? Yes No

Do you wear contact lenses? Yes No If yes, bring glasses to your eyeliner appointment as you cannot put in contact lenses directly after a procedure.

The above is complete and accurate as to my medical history.

*Signed: _____ (Client) Date: _____