Permanent Makeup

Amber Rose Skin Care  Medical Questionnaire

In order to provide you with the most appropriate treatment, please complete the following questionnaire. All of the information is strictly confidential.

Are you currently under the care of a physician? Yes/ No (circle one) If yes, for what?

Do you have any of the following medical conditions/problems? (Please circle yes or no)
Cancer Yes/No Diabetes Yes/No High blood pressure Yes/No Arthritis Yes/No
Frequent cold sores Yes/No Skin disease Yes/No Blood clotting Yes/No Seizure disorder Yes/No
Hormone imbalance, abnormality Yes/No HIV/AIDS Yes/No Hepatitis Yes/No Any active infection Yes/No
Herpes Yes/No Keloid scarring Yes/No Thyroid imbalance Yes/No Cardiac Valve Disease Yes/No
Hemophilia or other bleeding disorders Yes/No Other:_____

Have you ever had an allergic reaction to any of the following? (Please circle yes or no) Food Yes/No Latex Yes/No Aspirin Yes/No Lidocaine Yes/No Hydrocortisone Yes/No Tattoo pigments Yes/No Antibiotics Yes/No Do you need to be prescribed antibiotics prior to dental procedures or surgery? Yes/No Any allergies? _____ What reaction does your allergy cause? _____

What oral medications and dosage are you presently taking? (Please list)

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What Vitamins or Supplements are you taking? (Please list)

What topical medications, cleansers, creams, ointments, and or serums are you currently using on your face? (Please list)

Have you recently (within the last 2 months) had treatments such as facials, peels, microdermabrasion, etc. on your face? Yes/No (Please list)

Do you form thick or raised scars from cuts or burns? Yes/No

Do you get Hyper-pigmentation (darkening of the skin), Hypo-pigmentation (lightening of the skin) or marks after physical trauma? Yes/No

Which of the following best describes your skin? (Please circle) Always burns. Sometimes burns. Rarely burns. Never tans. Sometimes tans. Always tans.

Have you had any recent tanning or sun exposure that changed the color of your facial skin? Yes/No
Female clients: Are you pregnant or trying to become pregnant? Yes/No **Are you breastfeeding?** Yes/No **Are you using contraception?** Yes/No

- **I certify that the preceding medical, personal, and skin history statements are true and correct.**
- **I am aware that it is my responsibility to inform the technician of my current medical or health conditions and to update this history.**
- **A current medical history is essential for the permanent makeup technician to execute the appropriate treatment procedure.**

Signature _____ Date_____