NAME: **DATE OF BIRTH:**

ADDRESS:

PHONE NUMBER: **EMAIL:**

LIST ANY MEDICATIONS YOU'VE BEEN TAKING THE LAST 6 MONTHS:

HAVE YOU RECEIVED CHEMOTHERAPY OR RADIATION IN THE PAST YEAR? *Yes* *No*

HAVE YOU EVER HAD AN ALLERGIC REACTION TO THE FOLLOWING:

____ *Latex rubber*
____ *Medication*
____ *Metals*
____ *Dyes*
____ *Foods*
____ *Lidocaine*
____ *Cosmetics*

OTHER ALLERGIES:

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

____ *Retin A within the last 2 weeks*
____ *Anaemia*
____ *Prolonged bleeding*
____ *Trichotilomania*
____ *Low blood pressure*
____ *Artificial heart valves*
____ *Diabetes*
____ *Haemophilia*
____ *Fainting spells or dizziness*
____ *High blood pressure*
____ *Liver disease*
____ *Circulatory problems*
____ *Epilepsy*
____ *Tumours, growths or cysts*
____ *Thyroid disturbances*
____ *HIV*
____ *Hair loss*
____ *Hepatitis*
____ *Cancer*
____ *Existing skin condition*
____ *Chemical or laser peel within 6 weeks*
____ *Alopecia*
____ *AHA preparations in the last 2 weeks*
____ *Fat injections, Botox injections, or Collagen injections*
____ *Hypertrophic scars*
____ *Keloid scars*
____ *Healing problems*
____ *Do you scar easily?*
____ *Do you bruise or bleed easily?*
____ *Are you currently pregnant or nursing?*
____ *Existing skin condition*
____ *Regularly taking fish oil or vitamins*

LIP PROCEDURE

____ *Herpes*
____ *Fillers*

WHAT WOULD YOU LIKE TO IMPROVE / ACHIEVE?

FOR THERAPIST USE: NOTE PIGMENTS, BLADES, CARTRIDGES, TECHNIQUES TO BE USED FOR THIS CLIENT.

Please initial below confirming you have read and understood.

	I HAVE RECEIVED AN AFTER CARE LEAFLET AND I'M FULLY AWARE OF THE AFTER CARE PROCEDURES.
	I HAVE READ PRE-PROCEDURE ADVICE AND SIGNED PROCEDURE PERMIT FORM.
	I CAN CONFIRM THAT ALL OF THE INFORMATION PROVIDED ABOVE, IS CORRECT AND TRUTHFUL.
	I CONSENT TO BEFORE / AFTER PHOTOS TO BE TAKEN AND USED ON SOCIAL MEDIA.

CLIENT'S INTIALS: ***CLIENT'S SIGNATURE:***

TECHNICIAN'S NAME: ***TECHNICIAN'S SIGNATURE:***