CLIENT HISTORY

Name: _____ Date of Birth: _____

Address: _____
Street City State Zip

Home Phone: _____ Business Phone: _____

Cell Phone: _____ May we contact you at these numbers? _____

Email Address: _____ Other ID: _____

Referred by: _____

Emergency Contact: _____ Phone Number: _____

PROCEDURE(S) DESIRED: Check all of the following that apply.

- ☐ Upper eyeliner ☐ Partial eyebrows ☐ Lip liner ☐ Beauty mark
- ☐ Lower eyeliner ☐ Full eyebrows ☐ Full lip color ☐ Scar Camouflage
- ☐ Other: _____

ALLERGIES: Check if you have ever had an allergic reaction to any of the following and described what happened below.

- ☐ Latex rubber ☐ Tattoo ink/pigment ☐ Novovaine, Lidocaine ☐ Benzocaine, Tetracaine
- ☐ Lanolin ☐ Bacitracin Ointment ☐ Neomycin or polymyxin B ointment
- ☐ PABA ☐ Metal(s)
- ☐ Foods: _____

Other allergies: _____

Reaction: _____

EYES/EYEBROWS: Check all of the following that apply.

- ☐ Contact lenses ☐ Dry eyes ☐ Eye makeup sensitivities ☐ Blurred Vision
- ☐ Glaucoma ☐ Lasik /eye surgery ☐ Thyroid abnormalities ☐ Alopecia Areata (local)
- ☐ Alopecia Universalis (total) ☐ Pull out lashes/eyebrow compulsively (Trichotillomania)
- ☐ Other hair loss (describe): _____
- ☐ Eyebrow/Lash tinting
  Date of last service: _____
- ☐ Botox
  Date of last service: _____

Other eye disorders: _____

LIPS: Check all of the following that apply.

- ☐ Cold sores/fever blisters/herpes. If yes, an antiviral prescription is required prior to any lip procedure.
- ☐ Lip injections - Type: _____ Date: _____
- ☐ Other lip augmentation - Type: _____ Date: _____
- ☐ Teeth bleaching - Date: _____