Medical Health Form

Please note! Any clients who have medical conditions who are under the consultant or the GP and are on medication would need GP referral. If you will not have GP referral we won't be able to perform semi permanent make up treatment.

Name: .....

Address: .....

Date of Birth: ..... _____

Mobile: .....

List all the medications you have been taking in the last 6 month

_____.....
.....

Have you taken any of the following in the last 2 days; Aspirin, Ibuprofen, Alcohol?

Yes/No .....

Have you received chemotherapy or radiation treatment in the last year? Yes/No

Name of Doctor:

Surgery:

Allergies: have you ever had an allergic reaction to any of the following:

Lanolin	**Latex Rubber**	**Nuts**
Medication	**Metals**	**Hair dyes**
Drugs	**Foods**	**Lidocaine**
Paints	**Crayons**	**Glycerine**
Antibiotic ointments		

Anaesthetics (which ones) ……..
Other allergies (list) ……

Have you had a dental injection to numb your mouth?	**Yes/No**
Are you presently pregnant or breast feeding?	**Yes/No**
(We can't do treatment for pregnant or breastfeeding women)	
MRI scan scheduled in the next 3 months?	**Yes/No**
Laser or IPL scheduled in the next 3 months?	**Yes/No**
Do you give blood?	**Yes/No**
Prior to dental procedures do you receive antibiotic therapy?	**Yes/No**
I have had Botox or other injectables. Date:	**Yes/No**
Are you currently under the care of a doctor or hospital specialist?	**Yes/No**
(If yes you will need GP referral)	

Please fill out the following table with a tick to indicate if any of the following relate to yourself.

If you have any of these medical conditions in first column you will need GP referral.

Medical conditions:

Abnormal Heart Condition		***Palpitations***	
Mitral Valve Prolapsed		***Heart Murmur***	
Rheumatic Fever		***Pacemaker***	
Artificial Heart Valves		***Anaemia***	
Haemophilia		***Prolonged Bleeding***	
High Blood Pressure		***Low Blood Pressure***	
Circulatory Problems		***Diabetes***	
Epilepsy		***Auto immune system conditions***	
Thyroid Disturbances		***Liver Disease***	
Kidney Disease		***Glaucoma***	
Stomach Ulcers		***Tumours, Growths or Cysts***	
Cancer		***Tuberculosis***	
Stroke		***HIV***	
Prosthetic Hip or Joint		***Systemic Lupus Erythematosus***	
Hepatitis		***Shingles***	

Other conditions:……

Cataracts		Blurred Vision	
Dry Eyes		Do you suffer from eye Infections	
Alopecia		Occular Herpes	
Watery Eyes		Contact Lenses	
Eyelid Surgery		Chapped Lips	
Trichollomania		Recent Hair Loss	
Cold Sores (herpes simplex)		Dizinnes	
Gore-Tex Implants/Silicone Injections		Other Tattoos	
Fat Transfer Enhancement		Bruise or Bleed Easily	
Botox Enhancement		Use of Sun bed	
Dermal Fillers i.e restylane		Date of last eyelash/ eyebrow tint	
Do you have Healing Problems		Chemical or laser peel within 6 months	
Do you scar in a raised manner?		Retin A within 6 months	
Do your scars heal a darker colour than the rest of your skin?		AHA preparations within last 2 weeks	
Keloid Scars		Sensitivity to Cosmetics	
Acutance within 6 months		Do you tan regularly?	
Steroids within 6 months			

Others conditions .....

Have you had semi permanent make up before? YES/ NO

If YES please list – How long ago……. Name of Centre……..…...

What procedure…….. Were you pleased with the result?……..

I give my consent for further semi permanent make up work to be carried out – which again is undertaken at my request and in full understanding of all the points listed and understood

Client Name…….…….Signature…….Date……

Technician Name……Signature…….……...Date……

For re-touch procedure only (please tick)

My medical history did not change ☐

My medical history did change ☐

Please state what did change.....

Date of re-touch procedure..... Signature.....