ABOUT FACE
MAKEUP & PERMANENT COSMETIC SERVICES

Permanent Cosmetic & Microblading Services by
Diane M Bowman

GENERAL MEDICAL HISTORY/PROCEDURE CONSENT FORM

Today's Date _____/_____/_____

Name _____ Date of Birth _____/_____/_____ Email: _____

Ethnic Background, please include all nationalities _____

Address _____Apt. # _____City:_____

State _____ Zip _____ Home Phone (_____)_____ Cell (____)_____

Occupation: _____ If we call you at home, do you want confidentiality? ☐ No ☐ Yes

May we call you at work? ☐ No ☐ Yes If Yes, my work number is (_____)_____

Emergency Contact, Name _____ Phone (_____)_____Relationship_____

Who may we thank for referring you? _____

Procedure(s) desired: ☐ Brows ☐ Eyeliner ☐ Lips ☐ Camouflage ☐ Areola Complex ☐ Correction

List all medications you are presently taking

Name of drug	Mg. or mcg.	How many ea. day	Why it was prescribed to you
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List all medications you took in the last six months that you are no longer taking:

Name of drug	Mg. or mcg.	How many ea. day	Why it was prescribed to you
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Practitioner Signature _____ **Date** _____/_____/_____

GENERAL MEDICAL

ClientName: _____

Do you have? (check all that apply)

- ☐ **Fever Blisters/Cold Sores (Ever, even one time)**
- ☐ Glaucoma or other eye disease/disorder
- ☐ Thyroid/Grave's Disease
- ☐ Heart Disease
- ☐ Mitral Valve Prolapse
- ☐ Valve Implants
- ☐ Pacemaker
- ☐ Stents
- ☐ Diabetes requiring insulin
- ☐ Problems with healing
- ☐ Keloids
- ☐ Seizures
- ☐ Dermatological Disorder
  If so, what? _____
  Active or in Flare-ups? _____
- ☐ Hemophilia or Clotting Disorder
- ☐ Autoimmune Disorder
- ☐ Pre-existing nerve damage
- ☐ Tattoos: Colors you are sun sensitive to:

  _____
- ☐ Trichotillomania (pulling of hair, brows, lashes)
- ☐ Alopecia Totalis or Areata
- ☐ Allergies
  List: _____

  _____

Do you use? (check all that apply)

- ☐ Accutane (currently or within the past year)
- ☐ Antibiotics prior to dental procedures
- ☐ Steroids
- ☐ Retin-A, Glycolic Acid, Vitamin C or other Exfoliants
- ☐ Tanning Beds
- ☐ Eyebrow Tinting
- ☐ Eyelash Tinting
- ☐ Latisse
- ☐ Botox When_____
- ☐ Chemical Peels When_____
- ☐ Chemotherapy or Prophylactic dose of Chemotherapy
- ☐ Blood Thinners

Physician's
Name:_____
Address:
_____
Phone:
_____
Specialty:
_____

Signature of Practitioner

_____

Date _____/____/_____

GENERAL MEDICAL (Part 2) ClientName: _____

Have you had? (check all that apply)

- ☐ **Fever Blisters/Cold Sores (Ever, even one time)**
- ☐ Eye Infections (Are you prone to them)
- ☐ Vision Correction Procedure (Lasik, RK) within the past 3 months
- ☐ Heart Attack - When? _____
- ☐ Joint Replacement, Organ Transplant
- ☐ Eye Trauma
- ☐ Seizures
- ☐ Fainting Spells
- ☐ Hepatitis - What Type: _____
- ☐ Hepatitis Test - When? _____
- ☐ Fat Transfer Injections - If yes, where? _____
- ☐ Gore-Tex Implants - If yes, where? _____
- ☐ Aesthetic or Cosmetic Procedures
  If yes, where? _____
- ☐ Laser Treatments
- ☐ What type & why? _____

Are you? (check all that apply)

- ☐ Pregnant
- ☐ Planning cosmetic surgery
  If so, what & when?
  _____
- ☐ Currently under the care of a physician
  Describe:
  _____

Do you practice outdoor activities? Circle all that apply

Tennis	Swimming
Golf	Skiing
Gardening	Walking
Yoga	Running
Boating	Other

Signature of Practitioner

_____

Date _____/____/_____

INFORMED CONSENT TO PROCEDURE

Initial:

1. Are you pregnant or nursing? Yes [] No []
2. I absolutely understand and accept that such procedure is a process, often requiring multiple applications of color to achieve desirable results and the 100% success cannot be guaranteed. _____
3. I have received, reviewed and understand the pre-procedural instructions as given to me and agree to follow them. _____
4. Depending on the procedure(s), which I select, I accept responsibility for determining the shape, and position of eyebrows, eyeliners, lipliner and/or full lip color. _____
5. I understand that the color selection and color results in all procedures are not an exact science. _____
6. I understand that positioning of my procedures can be affected if I have elected or wish to elect cosmetic surgery, Botox or Restalyne and I assume this responsibility. . _____
7. I am aware that if I am to receive an MRI after the procedure, I must tell the Radiologist that I have iron oxide permanent cosmetics. _____
8. If I am a lens wearer, I realize that I must keep my lenses out the day of an **eyeliner procedure**. _____
9. I understand that this procedure will fade and this fading can alter the original pigment color and that this determines that it is a time for a touch-up visit. _____
10. I realize this is an elective cosmetic procedure and is not medically necessary. _____
11. It has been explained to me that the following possibilities may occur: Minor and temporary bleeding, bruising, redness or other discoloration; swelling; fever blisters on the lip area following lip procedures and/or fading or loss of pigment. _____
12. I understand that many lasers & IPL's (Intense Pulse Lights) including those used for hair removal, anti-aging, Photo Facials, removal of lines may or will turn permanent make up dark or even black. I agree to inform my esthetician or anyone operating such that I have permanent make up. _____
13. I give my consent to **Diane M Bowman** to confer with my physicians for medical information required for the safety of my procedures. _____
14. I agree to accompany my practitioner to the emergency room in the event they were to be accidentally stuck with my needle and take a blood test for their safety & disclose all test results to my practitioner. _____
15. I am aware that if an infection occurs after I have received Permanent Cosmetics to see with my primary physician or an emergency room, ***immediately***. _____

ACCEPTANCE:

I have read and understand these risks listed above and they have been explained to me. I certify that the information in the above questionnaire is accurate and my questions have been answered.

*****Please read all questions thoroughly before signing!!***

Signature of Client X_____

Signature of Practitioner _____**Date** _____/_____/_____