CLIENT CONSULTATION & HISTORY

NAME: _____

Please check if you have or previously had any of the following:

Y | N		Y | N	
❍ ❍	History of MRSA	❍ ❍	Botox® or similar *If yes, last time:
❍ ❍	Diabetes	❍ ❍	Lip Fillers/ Restylane®/ Juvederm®
❍ ❍	History of Cold Sores/ Fever Blisters / Herpes	❍ ❍	Forehead/ Brow lift/ Face Lift
❍ ❍	Hepatitis (A/B/C/D)	❍ ❍	Hemophilia/ Easily Bleed/ Clotting Disorder
❍ ❍	Keratosis	❍ ❍	Keloid Scarring/ Hypertrophy Scars/ Bruise easily
❍ ❍	Alcoholism	❍ ❍	Blepharoplasty/ Eye Injury/ Corneal Abrasion
❍ ❍	Hypopigmentation (Lighter spots, lack of pigment)	❍ ❍	Hyperpigmentation (Dark spots, from wounds/ sun)
❍ ❍	Take meds before Dental Work	❍ ❍	Difficultly Numbing for Dental Work
❍ ❍	Skin sensitivities to soap, lotion, makeup, etc.	❍ ❍	Anemia/ Anemic
❍ ❍	Complications from tattooing, branding, or piercing	❍ ❍	Using products with Retin-A, Glycolic Acid or Alpha Hydroxyl
❍ ❍	History of Epilepsy, Seizures, fainting, or Narcolepsy	❍ ❍	Are you wearing a Pacemaker?
❍ ❍	Currently Pregnant or Breast feeding	❍ ❍	Chemical Peel *If yes, last time:
❍ ❍	Autoimmune Disorder	❍ ❍	Brow or Lash Tinting
❍ ❍	Low or High Blood Pressure	❍ ❍	Do you smoke?
❍ ❍	Are you allergic to hair dyes?	❍ ❍	Are you sensitive to Petroleum based products?
❍ ❍	Do you have dry eyes?	❍ ❍	Allergies to Lidocaine, Epinephrine, Prilocaine?
❍ ❍	Cancer or History *If yes, what year?	❍ ❍	Oily skin
❍ ❍	Chemotherapy/ Radiation	❍ ❍	Accutane or Acne Treatment
❍ ❍	Skin disorders/ Eczema/ Psoriasis/ Skin Cancer	❍ ❍	Recent Surgeries or Injuries
❍ ❍	Tumors/ Growths/ Cysts/ Skin Diseases	❍ ❍	Tan by Booth or Sun in past 2 weeks
❍ ❍	Undergoing IVF treatment	❍ ❍	Thyroid disorder
❍ ❍	Taking Blood Thinners (e.g. Ibuprofen, Aspirin, etc.) If yes, list:	❍ ❍	Allergies to any medications or Hydrocortisone If yes, list:
❍ ❍	Allergies to any metal, food or LATEX If yes, list:	❍ ❍	Taking any medication or vitamins (e.g. Vit E) If yes, list:
❍ ❍	Have any other Diseases or Disorders If yes, list: _____	❍ ❍	Do you have a history of Heart attack or Stroke? ***Heart Condition risks include fainting, vomiting and infection including bacterial endocarditis***

I agree that the above information is true and accurate to the best of my knowledge. Any client reporting one or more of the above conditions should consult their physician before any body art procedure. Location on the body: Eyebrows

Signed: _____ Age: _____ DATE: _____

What would you like to improve about your eyebrows? _____

SPECIAL REQUESTS, CONCERNS OR REMARKS: _____

_____

BELOW IS FOR OFFICE USE ONLY

Previous semi-permanent makeup: ❍ Y ❍ N Skin Type: _____ Procedure(s): _____

FIRST VISIT: ____/____/____ TOUCH UP: ____/____/____ ____/____/____ ____/____/____ ____/____/____

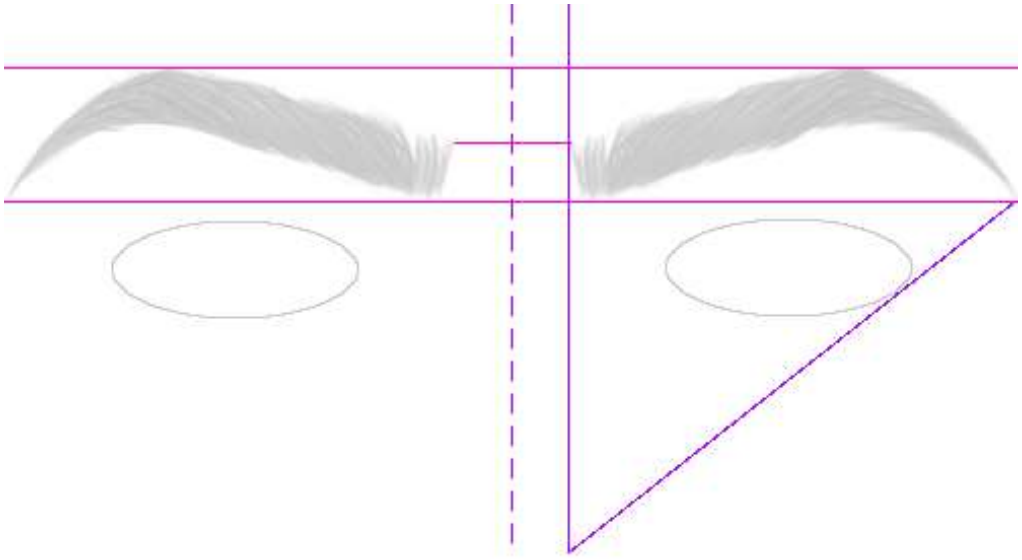
Instrument/ Needle#: _____ Lot/ ID#_____ Sterilization Exp. Date: _____

Invoice# and Date: _____ Supplier: _____

Undertone: ❍ Warm ❍ Cool

Desired Color:

Drops:	BLUE	RED	YELLOW	Corrector
Base Color				
Undertone				
Additive				



	Observations
Results	
#1 Ctrl	
#2 Ctrl	

Grade of satisfaction:

❍ Excellent ❍ Good

❍ Regular ❍ Bad

Design approval: I approve the eyebrow design presented to me.

Photos: Before, during and after of the procedure will be taken to show the evidential change and of the tested design the client has chosen to proceed with.

This waiver gathered information on the client, who was informed verbally of the Microblading procedure. Along with the information given by SV Brow Design, LLC, the client understands that following after care instructions renders the best results. By signing this contract, you agree with all written consent, therefore agreeing to follow through with the procedure described above.

Client Name (Print): _____

Signature: _____ Date: _____/_____/_____

Tech Name (Print): _____

Signature: _____ Date: _____/_____/_____