CONTOUR
PERMANENT MAKEUP
Tatiana Kuzyanova

MEDICAL CONSENT FORM

Client's Name_____

Are you currently under the care of a physician? Yes No

If YES, explain why_____

_____

Names of Physician's Office: _____
Names of Physician(s):_____

Please circle if you have or had recently any of the following. You may need a physicians release prior to your procedure:
DO YOU HAVE OR HAVE YOU HAD:

Yes No Anemia?
Yes No Sinus infections/chronic sinus congestion?
Yes No Blurred vision?
Yes No Bleeding problems?
Yes No Skin disease/skin lesions?
Yes No Shortness of breath?
Yes No Persistent cough?
Yes No Difficulty swallowing?
Yes No Frequent vomiting, nausea?
Yes No Dizziness?
Yes No Ringing in ears?
Yes No Heart attacks, heart disease, heart defects?
Yes No Stroke, hardening of arteries?
Yes No High blood pressure?
Yes No Asthma, other lung disease?
Yes No Hepatitis, other liver disease?
Yes No Stomach problems, ulcers?
Yes No **Pacemaker?**
Yes No **Diabetes?**
Yes No **HIV/AIDS?**
Yes No **Tumors, cancer/oncological diseases?**

Yes No Fainting spells?
Yes No Seizures?
Yes No Cold Sores? Herpes infections?
Yes No Hormone imbalance?
Yes No Plastic surgery?
Yes No Headaches?
Yes No **Blood-clotting problems/disease?**
Yes No Glaucoma?
Yes No Eye diseases?
Yes No Herpes infections?
Yes No Arthritis, rheumatism?
Yes No **Keloid scarring?**
Yes No **Leukemia?**
Yes No Thyroid, adrenal problems/disease?
Yes No **Epilepsy?**
Yes No **Organ Transplantation?**
Yes No **Eczema?**
Yes No **Psoriasis?**
Yes No **Blood transfusion?**
Yes No **Psychiatric care?**

CIRCLE APPROPRIATE ANSWER (leave Blank if you do not understand the question):

Yes No Do you take any medications for heart conditions?
Yes No Have you had a blepharoplasty for the last 6 month? If "Yes", then name the date_____
Yes No **Are you on any mood altering or anti-depression medication?**
(If I am on any medication for depression or any other mood altering prescription, I will advise my technician.
Initial_____)
Yes No Do you **currently have** a cold sore outbreak?
Yes No Have you **ever** had a cold sore? If yes, you must contact your physician for a prescription of ZOVIRAX or VALTREX
I have read the above information regarding ZOVIRAX/ VALTREX and understand its use is mandatory if I lip color procedures. x_____
Yes No Are you allergic to or ever had a reaction to Polysporin, Bacitracin, Neosporin, A&D, Vaseline, or any antibiotic, or topical healing ointment or products?
Yes No Do you have any allergies to any medication? _____
Yes No Do you wear contact lenses?

CIRCLE APPROPRIATE ANSWER (leave Blank if you do not understand the question):

Yes No Have you ever had lip implants or fillers placed into your lips for the last 6 weeks?
Yes No Have you had Botox injections for the last 6 weeks?

Yes No Do you intend to have any fillers or laser on your face after your permanent makeup application?
Yes No Do you have moles, freckles, blemishes, pimples, irritation of the skin of any kind, or other skin imperfections in or around the area of permanent makeup procedure?
Yes No Do you have any allergies to Novocaine, Lidocaine, Tetracaine, Epinephrine, or any other topical anesthetics?
Yes No Are you presently taking any medication that thins the blood?
Yes No Are you presently taking any corticosteroids?
Yes No Are you taking Accutane or have you had Accutane for the last year?
Yes No Are you taking Retin-A or Retinols or have you had Retin-A or Retinols for the last 30 days?
Yes No Have you had alcohol or blood thinners (Aspirin, Tylenol, Niacin, Vitamin E and/or Ibuprofen) for the last 48-72 hours?
Yes No Are you taking Coumadin or Heparin? **If YES, then you must have written permission from your physician.**
Yes No Have you had your eyebrows waxing for the last 72 hours?
Yes No Have you had eye surgery (Lasix/Cornea/Upper or Lower Blepharoplasty/Lens Repair…etc.) for the last 6 (six) months?
Yes No Have you been using eyelash growth serum (Latisse or there like) for the last 2 (two) weeks?
Yes No **Have you ever had cold sores around the eye area (eye herpes)? CONTRAINDICATION!!!!! You can get blind!!!**
Yes No Do you have hypersensitive eyes, watery eyes, tear duct plugs or severe allergies, refractive eye surgery? If you have or ever had hypersensitive eyes, watery eyes, tear duct plugs, severe allergies, refractive eye surgery, glaucoma, pressure in your eyes due to high blood pressure, then you must have written permission from your physician

WOMEN ONLY:

Yes No Are you or could you be pregnant?
Yes No Are you a breastfeeding?
Yes No Do you have your period at the moment of the procedure?
Yes No Are you taking birth control pills?

ARE YOU TAKING

Yes No Drugs, medications, over-the-counter, natural remedies?
Yes No Tobacco in any form?
Yes No Alcohol?

ALL CLIENTS:

Yes No Do you have or have you had any other disease or medical problems NOT listed on this form?
If YES, explain why_____
_____

Have you ever had any tattoo/permanent cosmetics applied? Yes No
If so please describe: _____
_____
Company provided the treatment _____
Date of the treatment _____
Did you sign any Consent and Release forms? Yes / No
Were before and after photos taken? Yes / No

I certify that I have head and fully understand the above consent and procedure permit. I accept full responsibility for complications that may arise or result during or following the tattoo/cosmetic procedure(s) that is to be performed at my request.

To the best of my knowledge, I have answered every question completely and accurately. I will inform my technician of any change in my health and/or medication.

Client (Print Name) Signature Date