ZenSations Medical Services Spa, LLC

~ Medical History ~

Permanent Makeup

Thank you for taking a few minutes to complete this important form. Your responses will help us to better meet your needs. All information will be held in the most professional and strictest confidence.

Name:_____ Today's Date:_____

Email Address:_____ Birth Date:_____

FL Address:_____

City:_____ Zip: _____

Cell #:_____ Home #:_____ Alt. #:_____

Alt. Address:_____

Referred by:_____

Procedure(s) Desired:_____
Race: Caucasian_____ African American_____ Asian_____ Hispanic_____ Other_____
Male:_____ Female:_____

1.	Do you have any allergies (including allergies to metal)?.....	Yes_____	No_____
2.	Have you ever had a tattoo?.....	Yes_____	No_____
3.	Have you every had a permanent make-up/cosmetic procedure done before?.....	Yes_____	No_____
4.	Are you diabetic?.....	Yes_____	No_____
5.	Are you pregnant, trying to become pregnant or currently nursing?.....	Yes_____	No_____
6.	Have you ever had a cold sore, fever blister or canker sore?.....	Yes_____	No_____
7.	On a regular basis do you consume any thing with caffeine?.....	Yes_____	No_____
8.	Do you consume any alcoholic beverage?.....	Yes_____	No_____
9.	Any history of skin disease, disorders or skin sensitiveness?.....	Yes_____	No_____
10.	Do you have trouble stopping even a small cut from bleeding?.....	Yes_____	No_____
11.	Do you bruise easily?.....	Yes_____	No_____
12.	Do you ever faint or feel faint?.....	Yes_____	No_____
13.	have you ever had seizures or convulsions?.....	Yes_____	No_____
14.	Do you have a tendency to shake or tremble?.....	Yes_____	No_____
15.	Do you have a nervous tendency to pick at your skin or cuticles, pull your brows, eyelashes or hair, bite the inside of your cheeks or any other nervous habits/tendencies?.....	Yes_____	No_____
16.	Do you have a tendency to worry a lot?.....	Yes_____	No_____
17.	Are you thirsty more than usual lately?.....	Yes_____	No_____
18.	Are you a smoker?.....	Yes_____	No_____
19	Are you a regular user of sleeping pills, marijuana, tranquilizers, pain killers, etc.?.....	Yes_____	No_____
20.	In the last 12 months have you had any eye surgery?.....	Yes_____	No_____
21.	Are you going through any life style changes at this time?.....	Yes_____	No_____
22.	Do you wear glasses?.....	Yes_____	No_____
23	Do you wear contact lenses?.....	Yes_____	No_____
24.	Do you have lens implants?.....	Yes_____	No_____
25.	Are you considered legally blind?.....	Yes_____	No_____
26.	Do you ever see double?.....	Yes_____	No_____
27.	Do you ever see colored halos around lights?.....	Yes_____	No_____
28.	Do you ever have pain or itching around your eyes?.....	Yes_____	No_____
29.	Are you susceptible to eye infections?.....	Yes_____	No_____
30.	Have you ever been told you have glaucoma?.....	Yes_____	No_____
31.	Do you have any other eye problems?.....	Yes_____	No_____

32.	Do you have high blood pressure?.....	Yes_____	No_____
33.	Do you ever get pains or tightness in your chest?.....	Yes_____	No_____
34.	Does every little effort leave you short of breath?.....	Yes_____	No_____
35.	Do you have a pacemaker?.....	Yes_____	No_____
36.	Do you have a heart murmur?.....	Yes_____	No_____
37.	Have you ever been told you have a heart problem of any kind?.....	Yes_____	No_____
38.	Do you ever use aspirin or any other blood thinners?.....	Yes_____	No_____
39.	Do you experience respiratory problems of any kind?.....	Yes_____	No_____
40.	Do you have asthma and or use an inhaler?.....	Yes_____	No_____
41.	Have you ever been told you have any blood disorders or diseases?.....	Yes_____	No_____
42.	Do you have any motor dysfunction?.....	Yes_____	No_____
43.	Do you go through periods of deep depression, anxiety or hopelessness?.....	Yes_____	No_____
44.	Do you have any hyper-pigmentation or lack of pigmentation areas?.....	Yes_____	No_____
45.	Do you or any of your family members have keloids (raised scar tissue)?.....	Yes_____	No_____
46.	Do you have any birthmarks or moles in the procedure area?.....	Yes_____	No_____
47.	Do you have any port wine stains?.....	Yes_____	No_____
48.	Do you have any scar tissue in the procedure area?.....	Yes_____	No_____
49.	Have you ever been tested for HIV?.....	Yes_____	No_____
50.	Do you have Alopecia?.....	Yes_____	No_____
51.	Do you have MVP (mitral valve prolapse)?.....	Yes_____	No_____
52.	Have you ever had any plastic surgery?.....	Yes_____	No_____
53.	Are you presently under a doctor's care?.....	Yes_____	No_____
54.	Have you ever taken the drug Accutane?.....	Yes_____	No_____
55.	Have you ever experienced any reaction to Novocaine or similar products?.....	Yes_____	No_____
56.	Do you sun bathe, use tanning equipment or participate in outdoor activities?.....	Yes_____	No_____
57.	Do you ever use teeth bleaching products?.....	Yes_____	No_____
58.	Are you considering or do you give blood on a regular basis?.....	Yes_____	No_____
59.	Do you take multivitamins?.....	Yes_____	No_____
60.	Do you have any implants or replacements?.....	Yes_____	No_____

If you answered **YES** to any of the questions, please refer to the # and give explanation on the following lines:

_____

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_____

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Please list ALL medications (prescription and over the counter) you are currently taking and have taken within the past 12 mons.

_____

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_____

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_____

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Please list any allergic reactions you have to medications:

_____

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Please list your facial skin care products (brand and type):

_____

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_____

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ALL INFORMATION HEREIN IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

Client's Signature:_____