FORINA

* Aesthetics *

MEDICAL HISTORY CONSENT FORM FOR MICROBLADING BROW TREATMENT

Client Name:_____

Doctor:_____

Surgery:_____

Your HomeAddress:_____

Your Occupation: _____ **Tel. No**: _____

Please specify any past or impending medical operations:

_____

_____

Please tick 'Yes' or 'No' to the following disorders or treatments:

	YES	NO
High or Low Blood Pressure?	[ ]	[ ]
Allergies (including bee products and or nickel)?	[ ]	[ ]
Pacemaker?	[ ]	[ ]
Heart Disease?	[ ]	[ ]
Asthma?	[ ]	[ ]
Diabetes?	[ ]	[ ]
Epilepsy?	[ ]	[ ]
Eczema?	[ ]	[ ]
Dermatitis / Psoriasis?	[ ]	[ ]
Rosacea?	[ ]	[ ]
Acne?	[ ]	[ ]
Vitiligo?	[ ]	[ ]
Skin Cancer?	[ ]	[ ]
Haemophilia?	[ ]	[ ]
Cold Sores?	[ ]	[ ]
HIV or Aids?	[ ]	[ ]
Hepatitis?	[ ]	[ ]
Bruise/Scar easily?	[ ]	[ ]
Contact Lenses?	[ ]	[ ]
Eye/Facial Surgery?	[ ]	[ ]
Sensitive Eyes?	[ ]	[ ]
Botox? Lip Fillers?	[ ]	[ ]
Collagen Injections?	[ ]	[ ]
Facial Peels?	[ ]	[ ]
Medication on a regular basis?	[ ]	[ ]
Take any Aspirin(s)?	[ ]	[ ]
Pregnant or Breast Feeding?	[ ]	[ ]

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If you have answered ‘yes’ to cold sores, please use your cold sore treatment for five days prior to your microblading treatment and then continue taking it for five days following it.

Do you have any other medical condition not included in the above questions? If yes please specify:~

_____

_____

_____

_____

It is the client's responsibility to disclose any known facts about any medical condition(s) and / or any medication that they may be taking. Not only can these factors influence the result of the treatment but it may force the technician to stop the procedure prior to completion due to complications.

I can confirm that I have answered all of the above questions honestly and to the best of my knowledge.

I certify that the all information supplied is accurate and that I know of no reason why I should not proceed with the treatment. I understand that should anything change between now and the day of treatment I will advise the practitioner.

NAME: _____

SIGNATURE: _____

DATE: _____