

Client Health Information Sheet

Name: _____

Address: _____ City _____ Zip _____

Phone: (Day) _____ Night: _____

May we contact you at these numbers if necessary? Yes No

Procedures Desired (check all that apply)

PMU Eyeliner PMU Eyebrows PMU Lip Liner PMU Full Lip PMU Beauty Mark

PMU Areola Repigmentation PMU Other _____

Have you ever had a herpes or cold sore? YES NO If yes, contact your physician for a prescription of ZOVIRAZ or some other Anti-Viral medication prior to any PMU Lip procedures.

I have read the above information regarding Anti-Viral medication and recommendations and understand its use is mandatory if I desire lip liner or full lip color procedures.

Signature: _____ Date: _____

Are you currently under the care of any physician? YES NO

If yes, why and for what treatment(s)? _____

Physician's Name: _____

Do you take antibiotics when going to the dentist? YES NO If Yes, why? _____

Do you suffer from: Allergies Moles or freckles at site of tattoo Hepatitis Heart Problems

Hemophilia Diabetes Skin Problems Scarring (Keloids) Eye Problems Epilepsy

HIV/AIDS Herpes Other: Please Explain: _____

Are you presently taking any medication which thins the blood? YES NO

Are you taking other medications including anti-depression or mood altering drugs? YES NO

If yes, please explain: _____

Are you pregnant or nursing? YES NO Do you wear contact lenses? YES NO

The above is complete and accurate as to my medical history and all answers have been completed accurately.

Signature: _____ (client) Date: _____