Standardized Form AAM
CONFIDENTIAL MEDICAL PROFILE

Name:		Date:	
Address:			
	(City)	(State)	(Zip)
Phone: ( )	Cell: ( )		
Area Code	Area Code		
Email:	Referred By:		

To avoid unforeseen complications please answer the following questions:

Are you under the age of 18 ? If YES please have Legal Guardian Initial here _____	**Yes** O	**No** O
Have you taken any aspirin or blood thinning products within the last 7 days ?	**Yes** O	**No** O
Any mood altering drugs within the last 8 hours ?	**Yes** O	**No** O
Do you have any history of Cold Sores, Herpes or Fever Blisters ?	**Yes** O	**No** O
Are you sensitive to Latex ?	**Yes** O	**No** O
Have you had a chemical or laser peel ? If YES, WHEN ? _____	**Yes** O	**No** O
Do you have problems with healing ?	**Yes** O	**No** O
Previous problems with Tattoos, or has your Physician advised you not to have a Tattoo at this time ?	**Yes** O	**No** O
Are you currently undergoing radiation or chemotherapy ?	**Yes** O	**No** O
Are you currently using Retin A or "Alpha Hydroxy" skin care products ?	**Yes** O	**No** O
Do you wear Contact Lenses ? *If YES, I understand that they must be removed during my eyeliner procedure and should NOT be replaced until the next day.*	**Yes** O	**No** O
Are you allergic to any Metals ? (e.g., you can only wear 14K gold)	**Yes** O	**No** O
Have you ever had any permanent make-up procedures before ?	**Yes** O	**No** O
Medication, including immunosuppressive such as anti-inflammatory or steroids ?	**Yes** O	**No** O
Withdrawal from caffeine products ?	**Yes** O	**No** O
Are you allergic to topical antibiotic preparations or desensitizers ? (e.g. Polysporin, Bacitracin, Neosporin or "Caine" family of drugs or Petroleum)	**Yes** O	**No** O
Is there any history of skin diseases or remarkable skin sensitivities ?	**Yes** O	**No** O
Are you presently taking Vitamins A and/or E in any form ?	**Yes** O	**No** O
Are you pregnant or nursing ?	**Yes** O	**No** O
Are you required to take antibiotics during dental or invasive medical procedures ?	**Yes** O	**No** O

Please check any of the following which pertain to you:

- O Heart Conditions
- O Allergies to Makeup
- O Accutane treatment
- O Dry eyes
- O Keloid or Hypertrophy scars
- O Diabetes
- O Stroke
- O Chest pains
- O Shortness of breath
- O Alopecia
- O Epilepsy/seizures of any kind)
- O Autoimmune disorders
- O Occular Herpes
- O Trichotillomania
- O Hepatitis/Jaundice/HIV
- O Kidney disease
- O Tendency to develop fever Blisters on the lip
- O Tendency to bleed excessively From minor injuries
- O Keloid formation
- O Hyper-pigmentation (Darkening of the skin)
- O Hypo-pigmentation (lightning of the skin)
- O Refractive Eye Surgery
- O Glaucoma
- O Cancer (any type)

Please explain any checked questions and list any other medical conditions & LIST ALL your medications:

_____
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_____

Doctors Name: _____ Phone: _____

Practitioner makes no attempt to, or claim to practice medicine. Some individuals will have complications related to permanent makeup application. These conditions are usually mild and last only a few days, however extreme complications are always a possibility. If you are healthy and there are no visible reasons restricting you from receiving a tattoo you must approve of the design and color before the application of your permanent makeup.

Client Signature: _____ DATE: _____