BROW LAMINATION MEDICAL HISTORY

Full Name: **Birth Date:**

Address:

City: **State/Province:** **Zip/Postal Code:**

Email: **Phone:**

Emergency Contact: **Phone:**

To perform the Brow Lamination procedure in a safe manner, please answer the following health questions truthfully. We will keep all information disclosed in a confidential manner and will use it only for purposes of determining whether you are an ideal candidate for this procedure.

Have you currently or previously had any of the following? (Circle Yes or No)

Yes No Hemophilia
Yes No Diabetes mellitus (diabetes)
Yes No Hepatitis A, B, C, D, E, F
Yes No HIV +
Yes No Eczema
Yes No Are you pregnant?
Yes No Do you have problems with healing of wounds?
Yes No Are you taking medication for blood thinning (anticoagulants)?
Yes No Have you tined your eyebrows in the last 6 months using brow henna, henna or tint/dye?
Yes No Have you consumed drugs or alcohol in the last 24 hours?
Yes No In the last 14 days, have you undergone any surgery in which you were exposed to radiation, or any medical interventions?
Yes No Have you ever been allergic to, or have had an allergic reaction to perm solution?
Yes No Have you ever been allergic to, or have had an allergic reaction to Hair Dye?
Yes No Have you applied Retin-A, AHA ("Alpha-Hydroxy Acids"), or exfoliated your brows within the last 72 hours?

Yes No Are you prone to herpes?
Yes No Infectious diseases / high fever
Yes No Epilepsy
Yes No Cardiovascular problems
Yes No Do you have a pacemaker?

Please list any skin diseases you've had current and past:_____

_____

Please list any allergies:_____

Please list any autoimmune diseases:_____

Please list any medications taken on a daily basis (including supplements):_____

_____