Timeless Allure

Dr Tracy A Miller

Permanent Makeup

PATIENT HISTORY FORM (Please complete all information)

Name	**Date**	**Gender** **Female / Male**	**DOB Age**
Address	**City**	**State**	**Zip**
Employer / Occupation		**Home Phone**	**Cell Phone**
How did you hear about Dr. Miller?		**E-Mail**	
Procedure Requested: Eyebrows / Lips / Eyeliner / Removal / Other:			

Patient agrees to make Dr Miller aware of any and all personal and relevant medical history, to the best of their ability. _____ Initial

1	YES	NO	Are you pregnant or nursing?	33	YES	NO	Are you diabetic? If so, Type 1 or Type 2?
2	YES	NO	Have you ever had cold sores or fever blisters?	34	YES	NO	Do you have any problems healing?
3	YES	NO	Do you have any allergies to latex?	35	YES	NO	Do you have a bleeding disorder or take blood thinners?
4	YES	NO	To your knowledge are you allergic or resistant to "-caine" numbing products like Lidocaine or Tetracaine?	36	YES	NO	Do you have any heart conditions?
5	YES	NO	Are you allergic or sensitive to any metals, for instance metals used for jewelry?	37	YES	NO	Do you have a history of stroke or heart attack?
6	YES	NO	Are you sensitive to petroleum-based products, Paba, Glycerin, Iron Oxides, or Epinephrine?	38	YES	NO	Do you have high or low blood pressure?
7	YES	NO	Are you sensitive or allergic to hand creams or body lotions?	39	YES	NO	Are you wearing a pacemaker?
8	YES	NO	Do you have allergies to makeup?	40	YES	NO	Do you tend to faint or become dizzy?
9	YES	NO	Are you allergic to hair dyes?	41	YES	NO	Do you have any seizure related conditions?
10	YES	NO	Do you have your lips injected with filler materials?	42	YES	NO	Do you personally have any history of cancer?
11	YES	NO	Do you have botox injections? Location and Date of last injection:	43	YES	NO	Are you undergoing radiation or chemo-therapy treatment currently?
12	YES	NO	Do you have any facial implants? Location:	44	YES	NO	Do you bruise easily for no obvious reason?
13	YES	NO	Have you had any facial plastic surgery?	45	YES	NO	Do you bleed excessively from minor cuts?
14	YES	NO	Have you had a laser or chemical peel within 6 months? Type and Date of last:	46	YES	NO	Have you experienced Hepatitis or Jaundice during the past 12 months?
15	YES	NO	Do you plan on having any laser or facial plastic surgery in the future?	47	YES	NO	Are you anemic?
16	YES	NO	Have you ever had any permanent cosmetics or tattoos applied? Types and Dates:	48	YES	NO	Do you have any medical condition that has resulted in a medical professional requiring you to pre-medicate with an antibiotic prior to a dental or other invasive procedure?

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17	YES	NO	If you have permanent cosmetics or tattoos, did you have any problems with healing after they were applied?	49	YES	NO	Do you have arthritis?
18	YES	NO	Do you routinely use Retin-A, glycolic, or other exfoliating products?	50	YES	NO	Do you have any Thyroid issues? Specify:
19	YES	NO	Do you wear contact lenses?	51	YES	NO	Do you have any type of herpes?
20	YES	NO	Do you have prosthetic implants?	52	YES	NO	Have you had Shingles?
21	YES	NO	Do you hyper-pigment? (Tendency to develop dark spots on the skin from wounds or sun)?	53	YES	NO	Do you have Alopecia
22	YES	NO	Do you hypo-pigment? (Lack of pigment on the skin)?	54	YES	NO	Do you have Vitiligo?
23	YES	NO	Do you scar easily from minor skin injuries?	55	YES	NO	Are you HIV positive
24	YES	NO	Do you tend to develop keloid or hypertrophic scars?	56	YES	NO	Do you have Hepatitis?
25	YES	NO	Do you have a history of skin sensitivities?	57	YES	NO	Do you have glaucoma or any other eye disease?
26	YES	NO	Are you now, or have you ever been on the acne treatment Accutane? Date discontinued:	58	YES	NO	Do you have dry eyes or Blepharitis?
27	YES	NO	Do you intentionally tan - Direct sun or tanning bed?	59	YES	NO	Do you have sinus problems?
28	YES	NO	Is your skin Oily / Dry / Combination ?	60	YES	NO	Do you menstruate? If yes: Next cycle date_____
29	YES	NO	Do you suffer from Trichotillomania?	61	YES	NO	Do you use tobacco? If you use tobacco you may heal slower and this affects the timing on scheduling a touchup appointment, if applicable.
30	YES	NO	Do you use Lip Stains or “Long-Lasting” Lipsticks?	62	YES	NO	Are you under treatment for depression?
31	YES	NO	Do you wear Eyelash Extensions or False Eyelashes?	63	YES	NO	Do you take prescription drugs? Please list on back.
32	YES	NO	Do you use whitening toothpastes?	64	YES	NO	Do you consume aspirin, Ibuprofen (Advil), Fish Oil or other Omega 3s or 6s daily?

If you answered “Yes” to any questions above, use the reverse side of this form to provide an explanation. Correlate your explanations to a specific question number. A “yes” answer does not indicate you are not an acceptable candidate for permanent cosmetics. It may simply be information that is valuable to me as each person’s body is unique, or it may indicate that based on any health conditions that affect healing, it would be advisable or required for you to consult with your physician before proceeding. If this form has not addressed a medical condition you have, please list it on the back.

Acknowledgments:
I understand that Dr. Miller schedules up to 3 hours specifically for my procedure appointment. Cancellations, rescheduling, or not showing for an appointment without adequate notice creates difficulty for all parties including other patients that would have been able to be seen. In order to keep prices more affordable for all, please have respect for the time dedicated to you to give you the best possible quality and experience. If you need to cancel or reschedule, the more notice you can give, the better. _____ **Initial**

Cancellation / Change / No Show of any appointment with less than a FULL 5 days notice will require a non-refundable reschedule fee of $100 to rebook and your initial deposit will be forfeit. This may even apply to unforeseeable events such as illness if you are a repeat offender. We appreciate your understanding of our time. _____ Initial

*Print Patient Name*_____

*Patient Signature*_____*Date*_____

*Practitioner Signature*_____*Date*_____

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