Timeless Allure
Dr Tracy A Miller
Permanent Makeup

PATIENT HISTORY FOR PERMANENT MAKEUP

(Please complete all information)

I. Patient Information:

Name: ______________________________ Date: ____________________

Address: ______________________________ Date of Birth: ____________________

City: ______________________ State: ______________ Zip:______________

Cell Phone: ______________________ Home Phone: ______________________*If OK to call at work

Work Phone*: ______________________ Email: ______________________

How did you hear about Dr. Miller?______________________________

Why do you want Permanent Makeup?______________________________

II. Type of Procedure(s) Requested: (circle) Eyebrows / Eyeliner / Lips / Removal / Other ______________

III. Medical History:

Have you ever had Permanent Makeup done before? (circle) **No / Yes**

If yes, what procedure(s):______________________________

By Whom? ______________________________ When: ____________________

Name of Color: ____________________ Method of Implantation?______________________

Were you pleased with the result? **No / Yes** If NOT, please explain why?

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What would you like to achieve with your Permanent Makeup?

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Please list any prescription(s), herbs, or vitamins you are taking or recently stopped taking (including Omega 3 or 6 - ex: Fish Oil):

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Do you take or use any of the following: (Circle) Accutane / Insulin / Blood Thinners / Omega 3 or 6 Supplements / Antabuse / Steroids (including Cortisones) / Aspirin / Ibuprofen (Advil) / High Blood Pressure Meds / Lash Growth Serums / Anti-Coagulants / Synthroid or other Thyroid replacement medications

I understand I **MUST** be off Accutane for twelve (12) months prior to all procedures! __________ **Initial**

Do you need to take Antibiotics or Anti-Viral Medicine prior to or after seeing your dentist? **No / Yes**

Do you wear lash extensions or false eyelashes: (circle) **No / Yes**

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Do you have facial Implants or Injectable Fillers on your face: (circle) **No / Yes** If Yes, where on the face and when was the procedure done?

____

Are you completely healed? (circle) **No / Yes** If No, explain

____

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Have you recently had or plan to have any elective or necessary facial surgery or laser procedures? (circle) **No / Yes**
If Yes, explain:

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*** Client is aware that a laser can fade Permanent Makeup or turn implanted color black and that it must be disclosed to the laser technician prior to receiving any laser treatments. _________ **Initial**

Do you have any known allergies? Please circle all that apply and list any additional allergies in the space provided:
Latex / Glycerin / Iron Oxides / Paba / Epinephrine / "-caine" (products such as Tetracaine, Lidocaine, etc) / Petroleum-based Products / Bacitracin / Other: ____

Have you ever had any difficulties / complications with dental procedures: (circle) **No / Yes** If yes, please describe:

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Do you have Dentures: (circle) **No / Yes** If Yes, which teeth? ___________________________________

Do you use any Retinoic Acids (Rx form of Vitamin A including Retin-A, Diferin, Adapalene, Renova, Tazorac, etc.) or Glycolic Acids regularly on the face or neck? (circle) **No / Yes** If Yes, what kind, strength and frequency of use?

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Do you swim or tan** (circle) Natural Sun / Tanning Sprays / Tanning Bed
Do not tan at least three (3) days before or after appointments. __________ **Initial

For Lip Patients: Do you use "all day" or "long-lasting" lipsticks or stains? **No / Yes** If Yes, you must stop use because they dry out the lips. If you are having a lip procedure, then your lips will be tough, making implanting color more challenging if not impossible. Stop wearing this type of lipstick and start exfoliating the lips daily by lightly brushing lips after brushing teeth or by gently rubbing the lips with a clean, damp washcloth. Begin wearing a moisturizing lip-gloss, balm or moisturizing lipstick as often as possible including before going to bed. _________ **Initial**

Have you ever in your life experienced a cold sore, fever blister, sun blister or Herpes Simplex? (circle) **No / Yes** If Yes, client acknowledges that she / he must get a prescription for Valtrex, Acyclovir, Famvir, Zovirax or other Anti -Viral medication and use for at least two (2) days before, day of, and two (2) days after the procedure if having a lip procedure.
________ **Initial**

Patient is aware that Fever Blisters etc. can occur with any lip procedure regardless of preventative measures and that such occurrence will drastically reduce the quantity of pigment that is implanted. Additional applications may be needed to complete the procedure to the patient's satisfaction and additional fees may be incurred. ________ **Initial**

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2424 Old US Hwy 6 & 50
SOLA Salon Studio #25
Grand Junction, CO 81505
(970) 640-6462

Please circle any of the following conditions below that you have or have had in the past.

Blepharitis	Mental Illness	Dermatitis	Lupus	Thyroid Issues
Hemophilia	Chemotherapy	Pregnant	Diabetes	Smoker
Mastectomy	Cancer	Alopecia	Conjunctivitis	Epilepsy
HIV	Hepatitis	Eye Disorders	Scar Tissue	Asthma
Oily Skin	Dry Skin	Combination Skin	Allergies to Cosmetics	Keloids
Seizures	Surgeries	Hyperpigmentation	Hypopigmentation	Radiation
Fainting	Sinusitis	Cold Sores	Fever Blisters	Retin A
Laser	Bruising	Hematomas	Trichotillomania	Renova
Allergies	Shingles	Injectable Fillers	Collagen	Accutane
Glaucoma	Bleed Easily	Healing Problems	Restylane	Differin
Cataracts	Facial Trauma	Hormone Therapy	Lip Implants (gortex)	Adapalene
Eczema	Steroids	Latex Allergy	Botox	Psoriasis
Dry Eye Syndrome	Metal Allergies	High/Low Blood Pressure	Plastic Surgery	Autoimmune Disorder
Blood Disorders	Heart Problems	Blood Thinners	Glacoma	Chapped Lips

Please explain any of the above:

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Please explain any other medical conditions:

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

________ **Initial**

____

Printed Patient Name

____ Date: ____________________

Patient Signature

____ Date: ____________________

Practitioner Name and Signature

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