

# Medical History Form

Date \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_

Postcode \_\_\_\_\_ Occupation \_\_\_\_\_

Business Phone \_\_\_\_\_ Home Phone \_\_\_\_\_ Mobile \_\_\_\_\_

Email \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Medical Practitioner \_\_\_\_\_ Phone \_\_\_\_\_

How did you hear about Perfect Brow

Design? \_\_\_\_\_

## General Medical Information

**ALLERGIES; Have you ever had a reaction following exposure to any of the following?**

PABA If yes, describe \_\_\_\_\_

Lanolin If yes, describe \_\_\_\_\_

Novocain If yes, describe \_\_\_\_\_

Lidocaine If yes, describe \_\_\_\_\_

Latex Protein If yes, describe \_\_\_\_\_

Metals If yes, describe \_\_\_\_\_

Foods If yes, describe \_\_\_\_\_

Other drugs If yes, describe \_\_\_\_\_

Other If yes, describe \_\_\_\_\_

**Which of the following is true to your skin type?**

☐ Always burn easily, never tan

- ☐ Always burn easily, moderately tan
- ☐ Burn moderately, tan gradually
- ☐ Always tan, burn minimally
- ☐ Tan quickly, rarely burn
- ☐ Heavy pigmented skin, never burn

**Have you ever suffered from any of the following?**

- |  |   |
|--|---|
| <input type="checkbox"/> Acute Rheumatism  | <input type="checkbox"/> Medical Oedema                                 |
| <input type="checkbox"/> Any condition already being treated by a GP, Dermatologist or another skin specialist<br>Specify_____ | <input type="checkbox"/> Nervous/psychotic condition<br>Specify_____    |
| <input type="checkbox"/> Osteoporosis  | <input type="checkbox"/> Trapped, pinched or inflamed nerve. Where_____ |
| <input type="checkbox"/> Arthritis   | <input type="checkbox"/> Bell's Palsy                                   |
| <input type="checkbox"/> Recent Operations<br>Details_____   | <input type="checkbox"/> Diabetes<br>Type_____                          |
| <input type="checkbox"/> Asthma  | <input type="checkbox"/> Other_____                                     |

**Are any of the following currently applicable to you?**

- |  |   |
|--|---|
| <input type="checkbox"/> Any metal pins or plates<br>Where_____  | <input type="checkbox"/> Contact Lenses   |
| <input type="checkbox"/> Areas of undiagnosed pain<br>Details_____   | <input type="checkbox"/> Contagious or Infectious diseases<br>Specify_____  |
| <input type="checkbox"/> Artificial tan until the product has faded from the skin  | <input type="checkbox"/> Cuts/Abrasions<br>Where_____   |
| <input type="checkbox"/> Bruises<br>Where_____   | <input type="checkbox"/> Drugs, medications or herbal remedies that cause photo-sensitisation, skin or blood thinning effects<br>Specify_____ |
| <input type="checkbox"/> Connective Tissue disorders (scleroderma)   | <input type="checkbox"/> Epilepsy   |
| <input type="checkbox"/> Cancer<br>Details_____  | <input type="checkbox"/> Fever  |
| <input type="checkbox"/> Cardio-vascular conditions (Thrombosis, phlebitis, hyper/hypotension, heart conditions)<br>Details_____ | <input type="checkbox"/> Implants, fillers, injectables in the treatment area<br>Details_____   |
| <input type="checkbox"/> Cataracts   | <input type="checkbox"/> Glaucoma   |

- ☐ Haemophilia or other clotting disorder
- ☐ Keloid scars  
Where\_\_\_\_\_
- ☐ Loss of Sensitivity  
Where\_\_\_\_\_
- ☐ Pregnancy
- ☐ Sunburn
- ☐ Suntanned skin

- ☐ Skin pigments conditions (vertigo, melisma, moles and pigmented naevi)  
Details\_\_\_\_\_
- ☐ Thyroid abnormalities
- ☐ Tattoos in treatment area
- ☐ Under influence of drugs or alcohol
- ☐ Undiagnosed lumps  
Where\_\_\_\_\_

**Previous treatment/s on area?**

- ☐ Waxing
- ☐ Threading
- ☐ Cosmetic Surgery
- ☐ Depilatory cream
- ☐ Sugaring
- ☐ Traditional tattoo
- ☐ Epilation
- ☐ Tweezing
- ☐ Shaving
- ☐ Cosmetic tattoo
- ☐ Micro pigmentation
- ☐ Micro derambrasion
- ☐ LED light therapy
- ☐ Bleaching

**Have you had any recent surgery?**

- ☐ Yes
- ☐ No

If yes, please provide details\_\_\_\_\_

**Are you planning on having any surgery in the near future?**

- ☐ Yes
- ☐ No

If yes, please provide details\_\_\_\_\_

**Are you suffering from any other medical conditions that have not been covered or is there anything else we should know that may affect your treatment?**

- ☐ Yes
- ☐ No

If yes, please provide details \_\_\_\_\_

**This is a true and accurate statement of my medical history, past and present.** I am aware that failure to disclose information pertinent to my treatment could have serious health ramifications. I am also aware that failure to disclose information pertinent to my treatment could have a direct bearing on the treatment outcome.

Date \_\_\_\_\_

Date \_\_\_\_\_

Client Name \_\_\_\_\_

Technician Name \_\_\_\_\_

Signature \_\_\_\_\_

Signature \_\_\_\_\_

**I consent to having the following treatment/s performed, plus any future treatment/s of the same area or type.**

- ☐ Upper eyeliner, Lash enhancement, Shading, Smudge or Wetline
- ☐ Lower eyeliner, Lash enhancement, Shading, Smudge or Wetline

- ☐ Eyebrow shading
- ☐ Eyebrow feather hair strokes
- ☐ Lip line
- ☐ Lip blend
- ☐ Full lip

Date \_\_\_\_\_

Date \_\_\_\_\_

Client Name \_\_\_\_\_

Technician Name \_\_\_\_\_

Signature \_\_\_\_\_

Signature \_\_\_\_\_

## Consent and Indemnity Form

**Please read the following carefully and tick the boxes when you agree with the statements. You may need to wait to talk to your technician before you can fill out this form.**

- ☐ The nature and method of the proposed procedure has been explained to me by a technician in addition to the usual risks and the possibility of complications during the following procedure.
- ☐ I understand that, in order to get the best possible result, I might need one or several treatments as discussed and explained by the technician. I will be charged for all subsequent treatments.

- ☐ I understand that there may be some degree of discomfort during the treatment and after treatment, including common skin reactions such as inflammation, redness and swelling, as well as other adverse effects explained to me in regards to having this procedure.
- ☐ I understand that each case is individual and results may vary from person or persons, or treatment to treatment due to many variables such as; hormonal changes, condition/colour of skin/hair, sun exposure, medications etc.
- ☐ I understand that this is a cosmetic treatment and that no medical claims are expressed or implied. In some cases further treatments are necessary to maintain/remove the pigment.
- ☐ I understand that although complications are very rare, sometimes an unexpected outcome may occur and that prompt treatment is necessary. In the event of any unexpected outcome, I will immediately contact the technician who performed the treatment. I will follow the technician's instructions to seek medical attention in the event of complications occurring.
- ☐ I have disclosed to the procedure technician all information that had been requested and agree to have the treatment performed on me.
- ☐ I acknowledge that I have been explained and received a Post procedure care form to take home and further agree to follow all post procedure instruction as I am directed.
- ☐ I acknowledge no refund will be given on this treatment.
- ☐ I acknowledge that the chosen treatment/s will only be carried out on my request. I accept that there is a risk that the treatment area may suffer harm during, or as a result of my requested treatment. I acknowledge that if I consent to the treatment, I shall not be entitled to take any action against the technician or clinic either at law or in Equity in respect of this treatment.
- ☐ I have not had any laser or IPL treatment within 21 days prior to this treatment.
- ☐ I acknowledge that I have been advised that I am not able to donate blood to the Blood Bank for a period of twelve months, following any permanent makeup procedure.

Client Signature \_\_\_\_\_

## Topical Anaesthetic Informed Consent

I have no known allergy to local anaesthetic or PABA (sunscreen). I know of no reason why I should not receive a topical anaesthetic to reduce my discomfort during the procedure. I have never suffered any adverse reaction to local anaesthetics administered in a dentist office or doctors surgery prior to procedure. I understand that topically applied anaesthetics vary greatly in effectiveness and durability.

I hereby request that a topical anaesthetic preparation be administered to minimise my discomfort during the Cosmetic tattoo procedure. I have been advised that it contains Lidocaine and that I may experience redness, itching or swelling following its use.

I am also aware that complications can and do sometimes occur during any procedure. I will follow the technician's instructions to seek medical attention, in the event of complications occurring.

Client Name \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_

## Photo Permission

Based on my selection below, I do hereby consent to the use of photographs taken of me before and after any procedure for any purpose which Perfect Brow Design deem appropriate. This may include advertisement, both internet and non-internet based.

**Please tick the type of photo permission you wish to allow Perfect Brow Design to use.**

- ☐ Full Face
- ☐ Eyes and Brows only
- ☐ Treatment area
- ☐ None

\*Please note that if you choose none or area only, photographs will still be taken before and after each procedure for the purpose of monitoring response to therapy.

Name \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_

# Shape and Colour Consent for Cosmetic Tattoo Procedures

## Acceptance of shape

I do certify that I have been given the opportunity to change the shape and the final shape is my choice. Depending on the procedure/s which I select, I accept responsibility for determining the shape and position of the eyebrow, eyeliners, lip liner, lip blend, full lip and/or other area. Photographs will be recorded to confirm what has been chosen by the client.

## Acceptance of colour

The technician has discussed my various colour options and tried to assist me in my colour selection. I accept responsibility for determining the colour of the eyebrow, eyeliners, lip liner, lip blend, full lip and/or other area. I understand that the finished colour of the implant is determined by my skin tone and colour. After viewing the colours, I certify that the colour of my choice is;

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Client Name \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_

Date\_\_\_\_\_

Client Name\_\_\_\_\_ Phone Number\_\_\_\_\_

- ☐ Brow Shading
- ☐ Feathered Hairstrokes
- ☐ Upper Eyeliner
- ☐ Upper Lash Enhancement
- ☐ Upper Eyeliner Shading
- ☐ Lower Eyeliner
- ☐ Lower Lash Enhancement
- ☐ Lower Eyeliner Shading
- ☐ Lip Line
- ☐ Lip Blend
- ☐ Full Lip

Machine\_\_\_\_\_

Needles\_\_\_\_\_

Colour Pigment\_\_\_\_\_

Colour Pigment\_\_\_\_\_

Colour Pgment\_\_\_\_\_

Notes\_\_\_\_\_

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Bleeding (area)\_\_\_\_\_ Bruising (area)\_\_\_\_\_

Swelling(area)\_\_\_\_\_ Discomfort(area)\_\_\_\_\_

Colour Penetration (area)\_\_\_\_\_ Client Satisfaction\_\_\_\_\_

Photo Permission\_\_\_\_\_

Procedure Cost per treatment \$\_\_\_\_\_

Procedure Total \$\_\_\_\_\_