THERABEAUTIC

BEAUTY ✻ SKINCARE

MICROBLADING

MICROBLADING CONFIDENTIAL HEALTH FORM

Full Name: _____

D.O.B. _____

Mobile: _____

Address: _____

Email: _____

Age: _____

Occupation: _____

Procedure**:** **Microblading**

Price: _____

Payment details: _____

Please list any medication you are taking, or have been taking for the last 6 months:

_____

_____

Are you currently under care of a doctor or hospital specialist? **Yes/No**

If Yes please provide details of Doctor and condition

_____

_____

Do you wear any of the following: **Contact Lenses/Glasses** or have any other concerning eye conditions Please give detail

_____

_____

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Have you recently undergone, or plan to undergo any elective or necessary surgery? **Yes/No**

If Yes please provide details below:

_____

_____

Have you ever had an allergic reaction to any of the following (please circle):

Latex	Lanolin	Vaseline	Medication	Metals	Hair Dyes
Foods	Lidocaine	Paints	Crayons	Glycerine	Plasters

Have you ever had a cold sore? _____

Are you currently taking any medication that thins the blood? **Yes/No**

Are you taking any of the following medications (please circle):

Accutane	Insulin	Steroids	Antabuse	Aspirin	Anti-Coagulant

High Blood Pressure Medication

Any Others: _____

Do any of these medical conditions apply to you? (please circle):

Pregnant	Hyper Pigmentation	Scar Heavily or Keloid scarring		Haemophilia
Diabetes	Hepatitis	TB or Lung Disease	Chemotherapy	Radiation
Infectious Disease	Cancer	Lupus	HIV positive	
Venereal Disease	Asthma	Iron Deficient	Anaemia	Skin Disorder
Mitral Valve Prolapse	Herpes Simplex II		Dry Eye Syndrome	
Alopecia	Epilepsy	Fainting or panic attacks		

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Have you had, or are planning to have any injectables, fillers or chemical peels? **Yes/No**

If yes please provide details below, including when you had or are planning to have these treatments

_____

_____

Do you suffer from or have any problems with scars healing? **Yes/No**

Client's Name: _____

Signature: _____

Date: _____