

MEDICAL CONSENT FORM

This page must be signed before consideration of any permanent makeup application

Full Name: _____

Are you currently under the care of a physician? Yes No

If YES, explain why _____

Names of Physician's Office: _____

Names of Physician(s): _____

Please circle if you have or had recently any of the following. You may need a physician's release prior to your procedure:

- Yes No Anemia
- Yes No Sinus infections/chronic sinus congestion
- Yes No Bleeding problems
- Yes No Skin disease/skin lesions
- Yes No Shortness of breath
- Yes No Persistent cough
- Yes No Difficulty swallowing
- Yes No Frequent vomiting, nausea
- Yes No Heart attacks, heart disease, heart defects
- Yes No Stroke, hardening of arteries
- Yes No Asthma, other lung disease
- Yes No Hepatitis, other liver disease
- Yes No Thyroid, adrenal problems/disease
- Yes No Glaucoma / Eye diseases
- Yes No Fainting spells
- Yes No **Seizures**
- Yes No Plastic surgery
- Yes No **Blood-clotting problems/disease**
- Yes No **Keloid scarring**
- Yes No **Leukemia**
- Yes No **Epilepsy**
- Yes No **Organ Transplantation**

- Yes No **Eczema**
- Yes No **Psoriasis**
- Yes No **Blood transfusion**
- Yes No **Psychiatric care**
- Yes No **Pacemaker**
- Yes No **Diabetes**
- Yes No **HIV/AIDS**
- Yes No **Tumors, oncological diseases**

CIRCLE APPROPRIATE ANSWER (leave Blank if you do not understand the question):

- Yes No Do you take any medications for heart conditions?
- Yes No Have you had a blepharoplasty for the last 6 months?
If "Yes", then name the date: _____
- Yes No **Are you on any mood altering or anti-depression medication?**
If I am on any medication for depression or any other mood-altering prescription, I will advise my technician. **Initial** _____
- Yes No Do you **currently have** a cold sore outbreak?
- Yes No Have you **ever** had a cold sore, Herpes infections?
If yes, you MUST contact your physician for a prescription of antiviral medication(Example: ZOVIRAX or VALTREX)
I have read the above information regarding antiviral medication and understand its use is mandatory if I have lip color procedures. Initial _____
- Yes No Are you allergic to or ever had a reaction to Polysporin, Bacitracin, Neosporin,A&D, Vaseline, or any antibiotic, or topical healing ointment or products?
- Yes No Do you have any allergies to any medication? _____
- Yes No Do you wear contact lenses?

CIRCLE APPROPRIATE ANSWER (leave Blank if you do not understand the question):

- Yes No Have you ever had lip implants or fillers placed into your lips for the last 6 weeks?
- Yes No Have you had Botox injections for the last 6 weeks?
- Yes No Do you intend to have any fillers or laser procedures on your face after your permanent makeup application?
- Yes No Do you have moles, freckles, blemishes, pimples, irritation of the skin of any kind, or other skin imperfections in or around the area of permanent makeup procedure?

- Yes No Do you have any allergies to Novocaine, Lidocaine, Tetracaine, Epinephrine, or any other topical anesthetics?
- Yes No Are you presently taking any medication that thins the blood?
- Yes No Are you presently taking any corticosteroids?
- Yes No Are you taking Accutane or have you had Accutane for the last year?
- Yes No Are you taking Retin-A or Retinoids or have you had Retin-A or Retinoids for the last 30 days?
- Yes No Have you had alcohol or blood thinners (Aspirin, Tylenol, Niacin, Vitamin E and/or Ibuprofen) for the last 48-72 hours?
- Yes No Are you taking Coumadin or Heparin? If YES, then you must have written permission from your physician.
- Yes No Have you had your eyebrows waxing for the last 72 hours?
- Yes No Have you had eye surgery (Lasix/Cornea/Upper or Lower Blepharoplasty/Lens Repair...etc.) for the last 6 (six) months?
- Yes No Have you been using eyelash growth serum (Latisse or there like) for the last 2(two) weeks?
- Yes No Have you ever had cold sores around the eye area (eye herpes)?
CONTRAINDICATION!!!!!! You can get blind!!!
- Yes No Do you have hypersensitive eyes, watery eyes, tear duct plugs or severe allergies, refractive eye surgery? If you have or ever had hypersensitive eyes, watery eyes, tear duct plugs, severe allergies, refractive eye surgery, glaucoma, pressure in your eyes due to high blood pressure, then you must have written permission from your physician.

WOMEN ONLY:

- Yes No Are you or could you be pregnant
- Yes No Are you breastfeeding
- Yes No Do you have your period at the moment of the procedure
- Yes No Are you taking birth control pills

ARE YOU TAKING:

- Yes No Drugs, medications, over-the-counter, natural remedies
- Yes No Tobacco in any form
- Yes No Alcohol

ALL CLIENTS:

Yes No Do you have or have you had any other disease or medical problems NOT listed on this form? If YES, explain why

Yes No Have you ever had any tattoo/permanent cosmetics applied?
If so please describe:

Company Provided the Treatment:

Date of the Treatment

Yes No Did you sign any Consent and Release forms?

Yes No Were before and after photos taken

I certify that I have read and fully understand the above consent and procedure permit. I accept full responsibility for complications that may arise or result during or following the tattoo/cosmetic procedure(s) that is to be performed at my request.

To the best of my knowledge, I have answered every question completely and accurately. I will inform my technician of any change in my health and/or medication.

Client (Print Name)

Signature

Date



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ABSOLUTE

- Insulin dependent diabetes
- Blood disorders / Haemophilia
- Hepatitis/ HIV/ aids
- Skin Cancer
- Undergoing radiotherapy or chemotherapy
- Heavy diseases of internal organs, liver and kidney failure
- Epilepsy
- Keloid Scarring
- Autoimmune diseases
- Fever
- Glaucoma
- Any ongoing illness
- Compromised Immune system
- Healing disorders / uncontrolled high blood pressure / pacemaker
- Acute bacterial or viral diseases
- Certain skin conditions (rashes, blisters, psoriasis, or eczema at the desired area of permanent makeup)
- Eye Herpes
- Pregnancy or lactation period
- Mental disorders

RELATIVE

- Alcohol or drug influence
- Sunburn
- Skin medication such as Accutane or steroids
- Active stage of cold / flu / runny nose
- Active stage of Herpes Simplex
- Stye



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