

ABOUT YOU

Date: _____

Client Name: _____

Date of Birth: _____

Address: _____

Suburb: _____ Post Code: _____

E-mail: _____

Mobile Phone: _____

Emergency Name/Contact: _____

Referred by: _____

How did you hear about us?: _____

Medication, including some supplements, can affect the healing and colour outcome of your procedure. It is important to be completely honest and detailed if you are taking any medication, or if any of the following applies to you:

ABOUT YOUR HEALTH

DO YOU HAVE ANY OF THE FOLLOWING?

Diabetes (Type 1 or 2) ☐ Yes ☐ No	Keloid Scarring ☐ Yes ☐ No
Epilepsy ☐ Yes ☐ No	Moles on the area ☐ Yes ☐ No
High Blood Pressure ☐ Yes ☐ No	Alopecia ☐ Yes ☐ No
Heart Problems ☐ Yes ☐ No	Eczema/ Dermatitis ☐ Yes ☐ No
Blood Clotting issues ☐ Yes ☐ No	Hyperpigmentation ☐ Yes ☐ No
Hepatitis ☐ Yes ☐ No	Anxiety ☐ Yes ☐ No
Herpes Simplex ☐ Yes ☐ No	Thyroid Disorders ☐ Yes ☐ No
Liver Disease ☐ Yes ☐ No	Autoimmune Disorders ☐ Yes ☐ No
Rosacea ☐ Yes ☐ No	Sunburn (2 weeks) ☐ Yes ☐ No
Trichotillomania ☐ Yes ☐ No	Immunodeficiency Virus ☐ Yes ☐ No
Anaemia ☐ Yes ☐ No	Other ☐ Yes ☐ No

Do you have any allergies? ☐ Yes ☐ No

Details: _____

Are you pregnant or breastfeeding? ☐ Yes ☐ No

Are you currently planning/trying to conceive? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No

Have you consumed alcohol in the past 24 hours? ☐ Yes ☐ No

IN THE LAST SIX MONTHS?

Recent Surgeries: ☐ Yes ☐ No Date: _____

Details: _____

ABOUT YOUR SKINCARE

Do you have any current skin concerns? ☐ Yes ☐ No

Details: _____

Do you have any existing cosmetic tattoos? ☐ Yes ☐ No

Details: _____

IN THE LAST SIX MONTHS?

Facial Laser/IPL: ☐ Yes ☐ No

Notes: _____

Facial Fillers: ☐ Yes ☐ No

Notes: _____

Muscle Relaxants: ☐ Yes ☐ No

Notes: _____

Chemical Peels: ☐ Yes ☐ No

Notes: _____

DOES YOUR CURRENT SKIN CARE CONTAIN ANY OF THE FOLLOWING COSMECEUTICAL INGREDIENTS:

AHA's (Alpha Hydroxy Acids) including glycolic and lactic acids ☐ Yes ☐ No

BHA's (Beta Hydroxy Acids) including Salicylic Acid ☐ Yes ☐ No

Vitamin A (Tretinoin/Retinoic Acid/Retinol) ☐ Yes ☐ No

Vitamin C (Ascorbic Acid) ☐ Yes ☐ No

Benzoyl Peroxide ☐ Yes ☐ No

Hydroquinone/ Kojic Acid ☐ Yes ☐ No

THERAPIST NOTES

Machine		Pigment Range / Colours	
Needle / Code		Skin Tone / Fitz	
Comments		Follow Up	
Artist's Name			

FITZPATRICK SKIN-TYPE CLASSIFICATION

SKIN TYPE	SKIN COLOUR	HAIR COLOUR (darkest)	EYE COLOUR (most common)	DESCRIPTION
I	White or very pale	Blonde	Blue, Grey, Green	Always burns, never tans
II	Pale White with beige tint	Chestnut or Dark Blonde	Blue	Always burns, sometimes tans
III	Beige to light brown (olive)	Dark Brown	Dark Brown	Sometimes burns, always tans
IV	Light to moderate brown	Black	Brown	Rarely burns, always tans
V	Medium to dark brown	Black	Brownish Black	Rarely burns, tans more than average
VI	Dark brown to black	Black	Black	Never burns

YOUR SKIN TYPE

WHAT IS YOUR SKIN TYPE?

Dry ☐ Yes ☐ No

Oily ☐ Yes ☐ No

Combination ☐ Yes ☐ No

Normal ☐ Yes ☐ No

Scarring (on the area) ☐ Yes ☐ No

ABOUT YOUR MEDICATION

ARE YOU TAKING ANY OF THE FOLLOWING?

Opioid Medication (Endone, Methadone, Tremadol, Oxycontin) ☐ Yes ☐ No Notes: _____

Chemotherapy/ Radiation Therapy ☐ Yes ☐ No Notes: _____

Tamoxifen ☐ Yes ☐ No Notes: _____

Prednisone ☐ Yes ☐ No Notes: _____

Thyroxine ☐ Yes ☐ No Notes: _____

HRT ☐ Yes ☐ No Notes: _____

Roaccutane/Accutane (within 12 Months) ☐ Yes ☐ No Notes: _____

Antibiotics / Doxycycline ☐ Yes ☐ No Notes: _____

Prescription Vitamin A ☐ Yes ☐ No Notes: _____

Warfarin/ Heparin/ Blood Thinners ☐ Yes ☐ No Notes: _____

Other Medication ☐ Yes ☐ No Notes: _____

Vitamins / Fish Oils or Herbs ☐ Yes ☐ No Notes: _____

EYELINER TATTOO ONLY

Are you wearing contact lenses? ☐ Yes ☐ No

PLEASE REMOVE

Have you had any eye surgery? ☐ Yes ☐ No

Notes: _____

Are you using lash enhancing serums? ☐ Yes ☐ No

Notes: _____

Do you/have you had glaucoma? ☐ Yes ☐ No

Notes: _____

Do you have cataracts? ☐ Yes ☐ No

Notes: _____

Do you have dry eyes? ☐ Yes ☐ No

Notes: _____

Any recent/current eye infections? ☐ Yes ☐ No

Notes: _____

RISKS ASSOCIATED WITH SEMI-PERMANENT TATTOO PROCEDURE

I understand that all semi-permanent procedures carry with them the possibility of complications and consequences including but not limited to fading of skin pigments, risk of infection, scarring, eye damage, inconsistent colour and bruising. If I would like the best results from the procedure then I will need to follow after-care instructions and book in for a 4-8 week follow up.

I have been informed that colour may vary as the skin heals. I have advised my provider if I am susceptible to cold sores. I understand that having a lip procedure may inflame cold sores, especially if I suffer from cold sores. I have consulted with a doctor and received treatment prior to any lip procedures if I am susceptible to cold sores. I have received detailed instructions for the aftercare of my treatment and I will strictly adhere to these instructions. I understand that this treatment is for cosmetic purpose only. That no guarantees have been made to me regarding the results, I am responsible for the after care using only the aftercare advice provided, if not I may have risk of infection or fading of pigments if not carried out fully. The general nature of tattooing as well as the specific procedure to be performed has been explained to me. I understand that I cannot donate blood for 6 months after the treatment.

I understand that the provider of this procedure takes no responsibility for any possible complications and consequences that may result from the procedure, particularly if I neglect to answer these questions properly, if I fail to accurately disclose my medical history or if I fail to take pre-procedure and or aftercare treatment. I will not hold the therapist responsible in the event of any damage and shall not be entitled to take action against him/her at Law or Equity for such treatment. I consent to before and after photographs of this procedure, which is at the therapist's discretion. I consent to the therapist applying the topical anaesthetic products containing Lidocaine, Tetrocaine, Benzocaine, Epinephrine to the treatment areas and reapplying where necessary. I am over the age of 18 years old. I am not pregnant. I have answered truthfully to all above questions on this form. If I experience any changes, reactions or concerns after my treatment I will notify my therapist immediately for further consultation.

Client Signature: _____

Date: _____