

Permanent Makeup Room, LLC
444 Lewis Hargett Cr, Unit 170, Suite 9, Lexington, KY, 40503 Certification #123565
Olga Parshenkova – Tattoo Artist and Esthetician
Permit #103565

MEDICAL HEALTH FORM

Please mark what type of medical pigmentation service you are receiving today

	Areola pigmentation
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	Scar Camouflage
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Name

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Address, postcode

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Occupation

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Date of Birth

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Work

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Home Phone

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Mobile

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Email

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List all the medications you have been taking in the last 6 months

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I have not taken Aspirin, Ibuprofen, Alcohol or illegal drugs in the last forty eight hours

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Have you received chemotherapy or radiation treatment in the last year?

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Name of Doctor:

Surgery:

Allergies: have you ever had an allergic reaction to any of the following:

Antibiotic ointments		Latex Rubber		Nuts	
Medication		Metals		Hair dyes	
Drugs		Foods		Lidocaine	
Paints		Crayons		Glycerine	

Anaesthetics (which ones)

Other allergies (list)

Have you had a dental injection to numb your mouth?

Are you presently pregnant or breast feeding?

MRI scan scheduled in the next 3 months

Laser or IPL scheduled in the next 3 month

Have you used eyelash growth products in last two week

Do you give blood?

Prior to dental procedures do you receive antibiotic therapy?

Please fill out the following table with a tick to indicate if any of the following relate to yourself.

Abnormal Heart Condition		Palpitations		Seizures	
Mitral Valve Prolapsed		Heart Murmur		Cataracts	
Rheumatic Fever		Pacemaker		Dry Eyes	
Artificial Heart Valves		Anaemia		Alopecia	
Haemophilia		Prolonged Bleeding		Watery Eyes	
High Blood Pressure		Low Blood Pressure		Eyelid Surgery Trichollomania	
Circulatory Problems		Diabetes		Cold Sores (herpes simplex)	
Epilepsy		Fainting Spells or Dizziness		Impetigo	
Thyroid Disturbances		Liver Disease		Blurred Vision	
Kidney Disease		Glaucoma		Do you suffer from eye	
Stomach Ulcers		Tumours, Growths or Cysts		Infections Ocular Herpes	
Cancer		Tuberculosis		Contact Lenses	
Stroke		HIV		Chapped Lips	
Prosthetic Hip or Joint		Systemic Lupus Erythematosus		Recent Hair Loss	
Hepatitis		Shingles		Auto immune conditions	
Gore-Tex Implants/Silicone		Retin A within 6 months		Keloid Scars	
Injections		Sensitivity to Cosmetics		Acutance within 6 months	
Fat Injections		Do you tan regularly?		Steroids within 6 months	
Botox Enhancement		Asthma		Do you have Healing Problems?	
Dermal Fillers i.e restylane		Chemical or laser peel within 6 months		Do you scar in a raised manner?	
Other Tattoos		AHA preparations within last 2 weeks		Date of last eyelash/ eyebrow tint	
Bruise or Bleed Easily		Use of Sun bed		Do your scars heal a darker colour than the rest of your skin?	

Others conditions

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Client Name	Signature	Date
Practitioner Name	Signature	Date