

**Permanent Makeup by Lindsay**

**Procedure-Consent Form**

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

I, \_\_\_\_\_ am over the age of 18, am not under the influence of drugs or alcohol and desire to receive the indicated procedure to be performed has been explained to me. (initials) \_\_\_\_\_.

Procedure(s) \_\_\_\_\_

I understand that when performing eyeliner, a cornea abrasion may occur. I was advised by True to You Makeup Inc., not to rub my eyes at any time before, or after my procedure. I will be very cautious when I apply my post procedure ointment and will stop the use of it, if my eyes become red or irritated. I am aware that I need to buy new mascara due to the bacteria harbored in mascara tubes as this may cause irritation to open skin. (initials) \_\_\_\_\_

I understand that a permanent skin pigmentation procedure carries with it possible complications and consequences associated with this type of cosmetic procedure, including but not limited to: infection, scarring, inconsistent color, spreading, fanning or fading of pigments. I understand that the actual color of the pigment may be modified slightly due to the tone and color of my skin. I fully understand that this is a tattoo process and is therefore not a science, but an art. I request this permanent skin pigmentation procedure(s) and accept the permanence of the procedure as well as the possible complications and consequences of said procedure (s). Initials \_\_\_\_\_.

I will strictly adhere to all pre- and post- procedure instructions. If I have ever had cold sores, I will consult with and strictly follow my doctor's instructions before contemplating any permanent cosmetic procedure around my lips. Initials \_\_\_\_\_

I hereby authorize the taking of before and after photographs of said procedure(s), which I understand may be used for advertisement. Yes \_\_\_\_\_ No \_\_\_\_\_

I hereby certify that I have read and initialed the above paragraphs and fully understand this consent and procedure form.

Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Technician: \_\_\_\_\_ Date: \_\_\_\_\_

Client Medical History Form

Date \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

Emergency Contact:

Person: \_\_\_\_\_ Phone: \_\_\_\_\_

Do you presently have or previously had any of the following:

(Circle Yes or No)

YES NO Botox

YES NO Diabetes

YES NO Lip Fillers/Restylane/Juvederm

YES NO Cold Sores/Fever Blisters

YES NO Blepharoplasty (Eyelid Surgery)

YES NO Hepatitis (A,B,C,D)

YES NO Brow Lift

YES NO Easy bleeding

YES NO Face Lift

YES NO Alcohol Consumption (never, rarely, 1or 2 drinks per day, per week, per month)

YES NO Eye surgery/injury/Corneal Abrasion

YES NO Abnormal Heart Condition

YES NO Contact Lens now

YES NO Chemical Peel (last treatment \_\_\_\_\_)

YES NO Pregnant now/ Breastfeeding now

YES NO Brow or Lash tinting

YES NO Oily skin

YES NO Accutane or acne treatment

YES NO Tan by booth or sun

YES NO Difficulty numbing with dental work

YES NO Taking blood thinner such as : Aspirin, Celebrex, Mobic, Alcohol, Coumadin

YES NO Allergic reaction any medications such as Lidocaine, Tetracaine, Epinephrine, Benzyl Alcohol, Vitamin E Acetate, etc

List: \_\_\_\_\_

YES NO Allergies to metal, food, etc.

YES NO Any diseases or disorders not listed?

List \_\_\_\_\_

YES NO Do you use skin care products containing Retin-A, glycolic acid or alpha hydroxyl?

YES NO Have you been diagnosed with depression, manic-depressive disorder (Bipolar), or any other mental disorders that needs to be addressed?

Please list medications (prescription or over-the-counter, including vitamins that you are  
Currently taking: \_\_\_\_\_

---

---

---

---

---

---

---

---

I agree that all the above information is true and accurate to the best of my knowledge.

Signature \_\_\_\_\_ Date \_\_\_\_\_