Cosmetic Ink 13330 Paseo Del Verano Norte San Diego, CA 92128
Call or Text (760) 509-5400

Client Information/Medical Profile

Name	Date	DOB	DL#
Address	City	State	Zip
How were you referred?	Email	May we leave a message at home?	

PROCEDURE DESIRED

Eyeliner Lash Enhancement Eyebrows Lip line Full Lip Color Lip Definer

Saline Removal Color Correction Areolas Other (please explain)

For all Lip procedures :If you have ever had a herpes or cold sore your **must** obtain a prescription of **Valtrex** or some other anti-viral medication. Please contact your physician. You will need enough for two appointments , for a total of 10 days.

I have read the above information regarding an anti-viral and understand its use is mandatory if I desire any type of permanent lip procedure.
*Signed:_____ (client)

1	YES	NO	Are you pregnant or nursing?	2	YES	NO	Are you **under** 18 years old?
3	YES	NO	Have you consumed alcohol in the last 24 hours?	4	YES	NO	Are you under treatment for depression?
5	YES	NO	Ever had cold sores or fever blisters?	6	YES	NO	Do dentists have problems numbing you?
7	YES	NO	Any latex, lanolin or glycerin allergies?	8	YES	NO	Do you have any seizure related conditions?
9	YES	NO	Had a laser or chemical peel within 6 months?	10	YES	NO	Do you take aspirin daily?
11	YES	NO	Diagnosed as obsessive-compulsive disorder? If yes, are you on medication for OCD? __y __n	12	YES	NO	Have you had any problems with previous Permanent Cosmetics or tattoos healing?
13	YES	NO	Do you already have permanent cosmetics? What year(s) were they applied?	14	YES	NO	Currently on radiation or chemo-therapy treatments? Which?
15	YES	NO	Do you use Retin-A, glycolic, or any exfoliants?	16	YES	NO	Have you ever used Accutane? When?
17	YES	NO	Do you wear contact lenses?	18	YES	NO	Are you wearing a pacemaker?
19	YES	NO	Are you sensitive to any metals?	20	YES	NO	Do you take prescription drugs? List below
21	YES	NO	History of skin sensitivities?	22	YES	NO	Do you pre-med before dentistry?
23	YES	NO	Do you have any heart conditions?	24	YES	NO	Do you have allergies to makeup?
25	YES	NO	Are you diabetic?	26	YES	NO	Do you have dry eyes?
27	YES	NO	Autoimmune disorders?(kidney, bone marrow tplant)	28	YES	NO	Do you intentionally tan?
29	YES	NO	Do you get migraine headaches?	30	YES	NO	Do you have any cancer history?
31	YES	NO	Have you had any lip augmentations?	32	YES	NO	History of stroke or heart attack?
33	YES	NO	Do you hyper-pigment? (Develop dark spots on the skin from wounds or sun)?	34	YES	NO	Do you hypo-pigment? (Develop white spots on the skin)?
35	YES	NO	Do you have any keloid or hypertrophic scars?	36	YES	NO	Do you have glaucoma or other eye disease?
37	YES	NO	Do you scar easily from minor skin injuries?	38	YES	NO	Do you use any Lash growing serums? How Long
39	YES	NO	Do you faint or suffer from blackouts?	40	YES	NO	Do you have High/low blood pressure?
41	YES	NO	Do you bleed excessively from minor cuts?	42	YES	NO	Do you have any sinus Problems?
43	YES	NO	Do you have facial prosthetics?	44	YES	NO	Do you have hepatitis, what type?
45	YES	NO	Have you had Herpes (you may need to pre-med)	45	YES	NO	Do you take thyroid meds?

Elizabeth Vierich makes no attempt to, or claims to practice medicine. Some individuals may have complications related to permanent cosmetic application. Complications are usually mild and last only hours but if more extreme complications may arise and if they do you are advised to seek medical attention. Your approval of design is necessary prior to application.

Client Signature:_____ Date: _____