Microblade Consent Form

Client Name_____

PRE_EXISTING CONDITIONS WHICH MAY AFFECT YOUR SUITABILITY FOR THE DESIRED PROCEDURE(S)

To help minimize any risks, which may be part of the procedure(s), the Client should answer the following questions truthfully and to the best of their ability, in order to assist the Specialist in ensuring that the Client is a suitable candidate for the procedure(s) requested. The Client acknowledges that any incomplete or inaccurate answers given to these questions may increase the possibility of complications and unwanted results from the procedure(s), and, as such, confirms that the answers given are true and accurate.

In the event that additional space is required, use the back of this form or additional paper; if the explanation is difficult to write briefly or concisely, please discuss it directly with the specialist.

If your answer is YES on any item, please provide explanation, including dates, durations, frequencies and circumstances as required:

Yes____No____ Are you pregnant or nursing_____

Yes____No____ Are you allergic to any medications_____

Yes____No____ Are you allergic to Latex, Glycerin, Rubber or PABA_____

Yes____No____ Are you allergic to topical anesthetics (lidocain, novocain, epinephrine, etc.)_____

Yes____No____ Are you allergic to topical salves (bacitracin, neomyacin, Neosporin, etc.)_____

Yes____No____ Are you diabetic_____

Yes____No____ Do you have any type of heart condition_____

Yes____No____ Do you have a mitral or prolapsed heart valve_____

Yes____No____ Do you have any joint replacements_____

Yes____No____ Do you require an antibiotic before seeing a dentist_____

Yes____No____ Do you have any type of blood disease_____

Yes____No____ Are you hemophiliac_____

Yes____No____ Do you have / have you had any form of hepatitis_____

Yes____No____ Are you on blood thinners (including asprin, ibuprofin, coumadin, etc.)_____

Yes____No____ Do you have an auto immune disorder_____

Yes____No____ Do you suffer from alcoholism_____

Yes____No____ Are you epileptic or subject to seizures_____

Yes____No____ Do you have glaucoma_____

Yes____No____ Do you have any dermatological disorders (eczama, rosacea, psoriasis, dermatitis, shingles, etc.)_____

Yes____No____ Do you have herpes_____

Yes____No____ Do you have (or are you prone to) keloid formation_____

Yes____No____ Do you have trichottillomania_____

Yes____No____ Do you have alopecia_____

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Yes____No____ Do you use cortisone_____

Yes____No____ Do you use glycolic acid_____

Yes____No____ Do you use Retin-A_____

Yes____No____ Have you used chemical peels_____

Yes____No____ Do you use steroids_____

Yes____No____ Do you have / have you had any form of cancer_____

Yes____No____ Are you undergoing chemotherapy_____

Yes____No____ Are you currently taking any medications (please list)_____

Yes____No____ Have you had any surgeries in the past 12 months_____

Yes____No____ Are you currently under a doctor's care for any condition_____

Yes____No____ Do you have Tourette's syndrome or are you prone to nervous tics_____

Yes____No____ Do you have any other diseases not mentioned_____

Yes____No____ Are you planning to have any cosmetic surgery_____

Yes____No____ Do you tan (tanning beds, lamps, or natural light)_____

Yes____No____ Have you had brow or lash tinting_____

Yes____No____ Are you under the age of 18? If yes, you must have the written legal consent of your parent or guardian on file with the Specialist before your procedure.

Signature of parent or guardian_____

Dated this _____ day of_____, *20*_____

Client name (printed)_____

Client signature_____