LA BC
LASH AND BROW CENTRAL

PERMANENT MAKEUP

RECORD BOOK

CLIENT NAME:

PERMANENT MAKE UP

CLIENT INTAKE FORM

CLIENT INFORMATION

Name: _____ Date: _____

Date of birth: _____ Age: _____ ☐ Female ☐ Male ☐ NB

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Emergency contact: _____ Phone #: _____

How did you hear about us? _____

Would you like to be added to our email list for news and exclusive offers? *Yes* ☐ *No* ☐

MEDICAL HISTORY

Do you have or have you had any of the following conditions? If yes, please select them:

- ☐ Autoimmune Disorder
- ☐ Aids/HIV
- ☐ Bleeding Disorder
- ☐ Cancer
- ☐ Cardiac Valve Disease
- ☐ Chemotherapy
- ☐ Depression/Mood disorder
- ☐ Diabetes
- ☐ Eczema
- ☐ Eye surgery/injury
- ☐ Glaucoma
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Herpes/Cold Sores
- ☐ History of MRSA
- ☐ Hypertronic Scarring/Keloids
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Pregnant/breastfeeding
- ☐ Psoriasis/Dermatitis
- ☐ Radiation
- ☐ Skin condition
- ☐ Serious Heart Condition
- ☐ Other:_____

Have you ever had an allergic reaction to latex? ☐ No ☐ Yes

Have you ever had an allergic reaction to antibiotics? ☐ No ☐ Yes

Do you have any other allergies: ☐ No ☐ Yes _____

List any medications/supplements you are currently taking: _____

_____

Have you taken any of the following in the last 2 days: Aspirin, Ibuprofen, Coumadin, Alcohol?

☐ No ☐ Yes Please specify: _____

Do you wear contact lenses? ☐ No ☐ Yes

Do you often have eye irritation, itching or watery eyes? ☐ No ☐ Yes

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CLIENT HISTORY

Have you had any permanent or semi-permanent makeup services done before? ☐ No ☐ Yes

If yes, what kind of permanent makeup did you do? _____

Have you ever had any of the following surgeries?

- Blepharoplasty (eyelid surgery) ☐ No ☐ Yes If yes, when? _____
- Forehead / brow lift ☐ No ☐ Yes If yes, when? _____
- Lasik eye surgery ☐ No ☐ Yes If yes, when? _____

Have you had any facial or dermatology services in the last 30 days? ☐ No ☐ Yes

Have you recently done a chemical peel? ☐ No ☐ Yes If yes, when? _____

Are you currently wearing lash extensions? ☐ No ☐ Yes

Do you have a tanned/sunburnt skin? ☐ No ☐ Yes

Have you used Latisse or any eyelash/eyebrow growth conditioner within the last 2 months? ☐ No ☐ Yes

Have you received Accutane (acne medication) within the last year? ☐ No ☐ Yes

Have you received Botox, Lip fillers, Restylane, Juvederm or Collagen in the last 6 months? ☐ No ☐ Yes

Have you used Retin-A, Renova, AHA, BHA, Retinoid or Retinol products in the last 3 months? ☐ No ☐ Yes

By signing below, you agree to the following:
I have completed this form truthfully and to the best of my knowledge. I agree to inform the technician of any changes in the above information. I agree that I do not have any condition/s that would make the requested treatment unsuitable. I agree to waive all liabilities toward my technician and the employer for any injury or damages incurred due to any misrepresentation of my health.

_____ _____

Esthetician (signature) *Client Name (signature)*

_____

Date

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I hereby consent to and authorize _____ to perform the following procedure: _____.

Although every precaution will be taken to ensure your safety and wellbeing before, during and after your microblading, please be aware of the following information and possible risks.

Please initial each statement:

_____ I am over the age of 18 and in sound mind, body, and health.

_____ I understand that I will have permanent and/or semi-permanent cosmetic (referred to on this form as PMU/SPMU) makeup applied using the highest standards of hygiene and that sterile disposable needles and pigment containers are used for each individual client, procedure, and visit.

_____ I understand and accept that permanent makeup is a process, often requiring multiple treatment visits to achieve desirable results and 100% success cannot be guaranteed.

_____ I have been advised that the pigment result may vary according to skin tones, skin type, ethnicity, age, lifestyle, post-procedure care and general skin conditions. And I understand no guarantee on exact color results can be given.

_____ I am aware that the true healed color will be visible 6-8 weeks after each procedure.

_____ I accept the responsibility for determining and agreeing to the color, shape, and position of the PMU/SPMU procedure as agreed upon during the consultation.

_____ I fully understand and accept that non-toxic pigments are used during the procedure and that the results will fade over time, however, some trace pigment may stay in the skin indefinitely.

_____ I have been advised that annual touch-ups are encouraged to maintain the integrity of the color.

_____ If an unforeseen condition arises in the course of the PMU/SPMU procedure, I authorize the technician to use his/her professional judgment in deciding what she feels is necessary under the given circumstances.

_____ I can confirm that I have received before and aftercare instructions and I will strictly adhere to such instructions. I understand that my failure to do so may jeopardize my chances for a successful procedure.

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_____ If I wear contacts, I am aware that I must remove them prior to an eyeliner procedure.

_____ I am aware that I must remove any false eyelashes prior to an Eyeliner/Lash Enhancement procedure. I am also aware that any lash enhancement serums or conditioners can affect the outcome of my Eyeliner/Lash Enhancement procedure.

_____ I acknowledge that my skin is vulnerable to infection directly after a PMU/SPMU application, and I am to contact my primary physician if I see any signs of infection.

_____ I understand that using cosmetics, excessive perspiration, and sun exposure should be limited until the skin has fully healed.

_____ Allergic reactions are always a possibility. I understand that a patch test/allergy test does not guarantee that I will not have an allergic reaction and I release the technician from liability should I develop an allergic reaction to any of the topical preparations, pigments, dyes or the anesthesia used in the procedure.

_____ I understand it's impossible to list every potential risk and complication. I agree to have been informed of possible benefits, risks, and complications including but not limited to: redness or other discoloration, temporary bleeding, bruising, swelling, irritation, pain, fading or loss of pigment, and cold sores on lips.

_____ I am aware that if I am to have an MRI after the procedure, I must tell the radiologist that I have iron oxide permanent cosmetics.

_____ I understand that laser hair removal procedures may turn lip pigment dark or black.

_____ I understand the positioning of my PMU/SPMU procedure can be affected if I elect to have cosmetic surgery, Botox, Restylane or other cosmetic or surgical procedures.

_____ I understand that correcting or touching up micropigmentation that was performed by others involves additional risks because of the existence of permanent pigments of unknown composition, brand, color, age, shape and other factors that my technician has no control over. I understand that additional appointments after the initial and follow up appointments may be required.

_____ I acknowledge that the procedure may result in a long lasting (many years) change to my appearance and that no representation has been made to me as to the ability to later change the results. I am aware that it can be costly to remove.

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——— I understand tattoo inks, dyes and pigments have not been approved by the federal Food and Drug Administration and that the health consequences of using these products are unknown.

——— I consent to the taking of before and after photos for the purpose of record keeping & documentation required by the Technician's insurance company.

——— I further authorize that exceptional photographs or results may be used in advertising or promotional materials and I give permission for such usage.

——— I am not pregnant or nursing, do not have Hepatitis, HIV/AIDS, and am not under the influence of any drug or alcohol at this time.

——— All medications and medical conditions have been disclosed to my technician as well as noted accurately and to the best of my knowledge on my intake/consultation form.

——— Being of sound mind and body, I hereby release and forever discharge the Technician at _____ from any and all claims of negligence, damages, or legal actions arising from or connected in any way with my PMU/SPMU procedure. I fully accept any and all responsibility for any consequences that might stem from my decision to have a PMU/SPMU procedure performed by _____.

By signing below I agree to the following:
I have completed this form to the best of my ability and knowledge. I agree to inform the technician of any changes in the above information. I agree that do not have any condition(s) that would make the requested treatment unsuitable. I will inform the technician of any discomfort I may experience at any time during my treatment to allow them to adjust accordingly. I agree to waive all liability toward my technician and the salon for any injuiry or damages incurred due to any misrepresentation of my health.

This agreement will remain in effect for this procedure and all future follow-ups conducted by the technician. I understand that this consent agreement is legal and binding. I have read and fully understand all information in this agreement. I am over 18 years of age and consent to the agreement and to the brow lamination procedure, or if I am under 18 years of age, I have had my parent or legal guardian consent to this agreement, and his or her relationship to me is as follows:

_____

By his or her signature below, he or she ratifies and consents to this procedure under these terms.

_____ _____

Esthetician (signature) *Client Name (signature)*

_____

Date

L I P S

PRE-CARE INSTRUCTIONS

PRE-CARE ADVICE

- No botox and/or cosmetic fillers around or on the area of the procedure.
- No chemical peels and/or laser treatments.
- No Retin-A and/or Accutane.
- No antibiotics.
- No steroids.
- For at least 5 nights prior to the procedure, exfoliate lips with a natural scrub (sugar and coconut oil) before bedtime.
- Apply Vaseline or Bepanthen lip cream after exfoliating the lips.
- Drink at least 8 glasses of water a day for hydration and improved lip surface.
- Do not take Aspirin, Niacin, Vitamin E, Ibuprofen or Omega 3 unless medically necessary, 48-72 hours prior to the procedure.
- Do not take blood thinners.
- Do not drink caffeine, energy drinks or alcohol for at least 24h before the procedure.
- If you have a history of cold sores we advise you to go see your doctor to obtain the proper prescription medication. Please start taking your medication 5 days prior to your procedure and continue a few days after.
- No working out the day of the procedure

L I P S
AFTER-CARE INSTRUCTIONS

AFTERCARE ADVICE

- Change your pillowcase when you get home. Please be advised that any pigment residue could stain your pillowcase for at least 1 week after your appointment.
- Day of the procedure: Lips will feel swollen, dark and very dry after your treatment. Pat lips gently with a wipe or tissue to remove excess lymph every hour or so on the first day. You may also apply ice packs to help if they are very swollen.
- Day 2-3: Apply a moisturizing lip ointment twice a day to moisten and prevent them from forming a crust. Allow lips to dry for 5 minutes prior to applying your aftercare lip balm. This should be done for at least 5-6 days post treatment.
- Day 4: Apply a moisturizing lip ointment at night to prevent scabs and dryness, continue to apply it for the entire week until the area is completely healed. Always use a Q-tip to apply the ointment. Once the lips are no longer tender, they may become flaky. This is normal.
- Do not pick or scratch them. Doing so can significantly reduce the amount of pigment that stays in the skin.

LIPS HEAL STAGES

PERMANENT MAKEUP

TREATMENT RECORD

CLIENT INFORMATION

Name: _____ Date: _____

Phone: _____ Mail: _____

INITIAL PROCEDURE

_____

_____

_____

_____

_____

_____

TOUCH-UP

_____

_____

_____

_____

PIGMENT/S USED	BLADE/S USED	ANESTHESIA USED	PAIN LEVEL 1-10