Evoque Permanent Makeup
INTAKE FORM

PERSONAL 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

SKIN AND LASH 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 his/her employer for any injury or damages incurred due to my failure to disclose any existing or past health conditions.

Client Printed Name:	Signature:	Date:

Technician:	Signature:	Date: