



Client Medical History Form

Date _____

Name _____ DOB _____

Address _____

City _____ State _____ Zip Code _____

Phone Number _____ Email Address _____

Emergency Contact Person _____ Number _____

Please circle any of the following that you may have had or currently have:

- History of MRSA Diabetes Hepatitis Forehead/Brow Lift
- Cold Sores/viral infections/breakouts Epilepsy Claustrophobia
- Rash/skin irritation Psoriasis near the treated area Bleed easily Facelift
- Alcoholism Pregnant/Breast Feeding Abnormal Heart Condition
- Take medication before dental work Brow Lash Tinting Autoimmune disorder
- Oily Skin Accutane/Acne Treatments Tanning Tumors/Growths/Cysts
- Difficulty numbing with dental work Blood thinners (aspirin, ibuprofen, alcohol, coumadin)

Cancer/Radiation (last treatment) _____

Allergic reactions to Lidocaine, Tetracaine, Epinephrine, Dermacaine, Benzyl Alcohol, Caropol, Lecithin, Propylene Glycol, Vitamin E Acetate, etc _____

Allergies to metals, food, etc _____

Any diseases or disorders not listed? _____

Do you use any skin care products containing Retin A, Glycolic Acid, or Alpa Hydroxyl?

Please list any medications you are taking: _____

Please circle “yes” or “no” to the following questions:

Did you go to the gym or engage in physical activity today? Y or N

Did you drink more than one cup of coffee today? Y or N

Did you tan or have you exposed yourself to the sun? Y or N

Have you taken any aspirin, niacin, vitamin E, or ibuprofen in the 24 hours prior to this visit? Y or N

Did you consume any alcohol today? Y or N

Have you waxed or tinted your brows within the past 3 days? Y or N

Have you had any botox or facial injections within the past month? Y or N

Have you used any Retin-A or AHA products within the past 2 weeks? Y or N

Have you had any laser treatments or chemical peels within the last month? Y or N

Have you had any microdermabrasion or dermaplaning treatments within the past 2 weeks? Y or N

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

Print Name _____

Date _____

Signature _____

Witness _____

Date _____

About Microblading/ Semi-permanent Eyebrow Enhancement **(Please read the following carefully and in its entirety.)**

Microblading is form of semi-permanent cosmetic tattooing and is meant to help enhance the appearance of eyebrows. During this procedure, eyebrows can become more defined, helps them appear more “filled-in,” and/or reshape the natural eyebrow. This is a technique that is meant to leave you with very natural look as the microblading technique results in small hair-strokes done by a microblade which deposits pigment into the epidermis of the skin. This procedure does not go as deep as traditional tattoos would penetrate and on average lasts approximately 18 months. Touch-ups can be performed 6 weeks after the initial procedure and is recommended yearly afterwards.

On rare occasion, the pigment may migrate under the skin. This procedure may be uncomfortable for some people. Pigments will fade. Immediately following the procedure, the pigment may appear up to 50% darker than desired. In rare cases, delayed allergic reactions to the pigment may occur. Allergic reactions to anesthetic can occur. This procedure cannot be performed to any person under the age of 18 year old. Infections can occur if aftercare instructions are not followed correctly. There may be swelling and redness following the procedure. You may experience minor bleeding. Possible scarring may occur, however, this is extremely rare.

Possible Risks, Hazards, or Complications

Pain: Some level of pain may be experienced even after the topical anesthetic has been used. Anesthetics can work differently on some people versus others.

Infection: Infection is very unusual. The areas treated must be kept clean, and only freshly cleansed hands should touch these areas. See “after care” sheet for instruction of care following the microblading procedure.

Uneven pigmentation: This can result from poor healing, infection, bleeding, or many other causes. Your follow-up appointment will likely correct any uneven appearance.

Asymmetry: Every effort will be made to avoid asymmetry, but our faces are not symmetrical so adjustments may be needed during the follow-up session to correct any unevenness.

Excessive swelling or bruising: Some people bruise or swell more than others. Ice packs may help reduce the swelling. The swelling or bruising typically disappears in 1-5 days. Some people do not experience this and some may experience it for longer.

Anesthetics: Topical anesthetics are used to numb the area to be microbladed. Lidocaine, Prilocaine, Benzocaine, Tetracaine, and/or Epinephrine cream and/or liquid are used. If you are allergic to any of these, please inform you technician.

MRI: Because pigments used in microblading procedures containing inert oxides, a low level magnet may be required if you need to be scanned by an MRI machine. You must inform your MRI technician of any tattoos, permanent cosmetics and microblading procedures.

The alternative to these possibilities is to use traditional cosmetics and NOT undergo the Microblading/Semi-permanent eyebrow procedure. I acknowledge all of the above listed risks, hazards and complications.

Signature _____

Date _____

Microblading/ Semi-permanent Eyebrow Enhancement Consent Form

I (print name) _____ hereby consent to and authorize

(tattoo artist/technician's name) Cassie Beals to perform the microblading/semipermanent eyebrow enhancement on (today's date) _____ at

location: Dr. K's Med Spa and Largo Clinic
10500 Ulmerton Road
Suite 360
Largo, FL 33771

_____ (Initial) To the best of my knowledge, I do not have any physical, mental, or medical impairment or disability that might affect my well-being as a direct or indirect result of my decision to have this procedure done at this time.

_____ (Initial) I have voluntarily elected to undergo this procedure after the nature and purpose of this treatment has been explained to me, along with the risks, hazards, and complications that could arise.

_____ (Initial) Although it is impossible to list every potential risk and complication, I have been informed of possible benefits, risks, and complications. I also recognize there are no guaranteed results and that independent results are dependent upon age, skin condition, and lifestyle.

_____ (Initial) If an unforeseen condition arises in the course of this procedure, I authorize my technician to use their professional judgement to decide what they feel is necessary under the given circumstances.

_____ (Initial) I accept the responsibility for determining the color, shape and position of the microblading procedure as agreed during consultation.

_____ (Initial) I understand that this is a 2 and sometimes 3-step process and I will be required to return no later than 60 days after the initial procedure for further treatments/touch ups to obtain the expected results and incur an additional charge \$100. Anytime past the 60-day period will incur a charge of a 3 month to 12 month touch up of \$250.

_____ (Initial) I have read and understand the post-treatment home care instructions. I understand how important it is to follow all instructions given to me for post-treatment care.

_____ (Initial) I have also, the the best of my knowledge, given an accurate account of my medical history, including all known allergies or prescription drugs or products I am currently ingesting or using topically.

_____ (Initial) I acknowledge that the proposed procedure involved risks inherent in the procedure, and have possibilities of complications during and/or following the procedure such as infection, poor color retention, and hyper-pigmentation.

_____ (Initial) I fully understand and accept the fact that even once the colors fade, the pigment itself may stay in my skin indefinitely.

_____ (Initial) I have been informed that the highest standards of hygiene are met and that sterile, disposable needles and pigment containers are used for each individual client, procedure and visit.

_____ (Initial) I understand the result of this procedure is determined by the following: medication, skin characteristics (dry, oil, sun-damaged, thick or thin skin types, disorders, etc) personal pH balance of the skin, alcohol intake and smoking, and post-procedure aftercare.

_____ (Initial) I understand I may resume normal activities following the procedure, however, using cosmetics, excessive perspiration and exposure to the sun should be limited until the skin has fully healed.

_____ (Initial) I have been advised that the true color will be seen 1 month after each procedure and that the pigment may vary according to skin tones, skin type, age, and skin condition. I understand that some skin types accept pigment more readily and no guarantee on exact color can be given.

I have read and fully understand this agreement and all information detailed above. I understand the procedure and accept the risks. All of my questions have been answered to my satisfaction and I consent to the terms of this agreement. I do not hold the esthetician/microblading technician/or tattoo artist, whose signature appears below, responsible for any of my conditions that were present, but not disclosed at the time of this procedure, which may be affected by the treatment performed today. Being of sound mind and body, I hereby release any and all responsibility. I accept any and all responsibility myself for any consequences that might stem from my decision to have any cosmetic tattoo procedure performed by (tattoo artist) Cassie Beals at Dr. K's Med Spa and Largo Clinic.

Print Name _____ Date _____

Signature _____

Technician/ Tattoo Artist _____ Date _____

Model Photo Release Form

I hereby give permission to (tattoo artist) _____

to use my photographic likeness in all forms an media for advertising, exposition displays, trade, teaching materials and any other lawful purposes.

Print Name _____

Date _____

Signature _____