Innovative Aesthetics Medical Spa & Laser Center

Microblading Client Medical History

Client Name: _____ Date Of Birth: ___/___/_____

Street address: _____ State: _____ Zip Code: _____

Phone: Cell _____ Home _____ Work _____

E-mail address: _____

(We notify our clients about Monthly Specials, Special Events, and Discounts by e-mail.)

Emergency Contact _____ Number: _____

Relation of the Emergency Contact: _____

How did you hear about us?(EX. friend, radio, tv, etc)_____

(If you were referred by a friend, please include their first & last name so we can credit their account)

MICROBLADING

Microblading is the latest semi-permanent procedure to enhance the appearance of eyebrows. Trained Artists use a microblading tool to implant ink (also called pigment) superficially into the skin. Each stroke into the skin creates the appearance of a hair stroke and looks just like real hairs.

It is important to read and fill out all the microblading forms in order to make sure this procedure is the right one for you.

Contraindications of this procedure are: currently pregnant, breastfeeding, undergoing chemotherapy, have epilepsy, a pacemaker, major heart problems, organ transplant, Accutane use in the last 12 month, or Botox (or similar products) in the last 2 weeks.

If your skin has irritations – psoriasis near the area, rashes, sunburn, current acne breakout in the areas of the procedure, or currently ill with illnesses i.e. – cold, flu, cold sore, please wait until skin is cleared or you are no longer ill before having this procedure done.

You must bring a valid photo ID to *ALL* Microblading appointments.
(This include follow-up appointments)

Please expect your first session to last 2-3 hours. Follow-ups will not take as long

If you have any questions, please contact Innovative Aesthetics Medical Spa & Laser Center at 319-365-7721.

Medical History Form

Are you currently under care of a physician? YES / NO

If yes, please explain: _____

Are you on any medications (include supplements – fish oil, krill oil, vitamins, etc.)? YES / NO
If yes, please list: _____

Are you allergic to any medication or supplements? YES / NO

If yes, please list: _____

Are you currently pregnant, trying to get pregnant or breastfeeding? YES / NO

Have you used Accutane or the generic form in the last 12- months? YES / NO

Do you have or previously had any of the following:

YES / NO Taking blood thinners such as: Aspirin, Ibuprofen, Alcohol, Coumadin, etc.

YES / NO Have an autoimmune disorder

YES / NO Currently have cancer

YES / NO Do you use skin care products containing Retin-A, Glycolic Acid, or Alpha Hydroxyl?

YES / NO Abnormal heart condition

YES / NO Diabetes

YES / NO Hepatitis A B C D

YES / NO HIV

YES / NO Currently on steroids, such as prednisone

YES / NO Botox or similar products (Date of last treatment:_____)

YES / NO Chemical Peel (Date of last treatment: _____)

YES / NO Forehead/brow lift/facelift

YES / NO Excessive alcohol intake

YES / NO Brow lash tinting

YES / NO Use a tanning bed

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

Client Signature: _____ Date: ____/____/_____

Artist Signature: _____Date: ____/____/_____