MEDICAL HEALTH FORM

NOUVEAU CONTOUR
PERMANENT COSMETICS

Client name	

Address

E-mail	Tel No	Gender
		Female / Male

Doctor / GP

Surgery name and address

Emergency contact name / number

List all the medications you have taken in the last 6 months

Have you taken any of the following in the last 2 days? (please indicate Y/N)

Aspirin	Y/N	Ibuprofen	Y/N	Coumadin	Y/N	Alcohol	Y/N	

Have you received the following treatment in the past 12 months? (please indicate Y/N)

Chemotherapy	Y/N	Radiotherapy	Y/N	

Have you ever had an allergic reaction to any of the following? (please indicate Y/N, if 'Yes' provide details below)

Adrenaline	Y/N	Anaesthetics	Y/N	Crayons	Y/N	Drugs	Y/N	Foods	Y/N
Glycerine	Y/N	Hair dyes	Y/N	Lanolin	Y/N	Latex	Y/N	Lidocaine	Y/N
Medication	Y/N	Metals	Y/N	Nuts	Y/N	Paints	Y/N		

Do you have any other allergies? (please list them here and give details of reactions)

MEDICAL HEALTH FORM

NOUVEAU® CONTOUR PERMANENT COSMETICS

Have you experienced, or currently have, any of the following medical conditions? (please indicate Y/N, if 'Yes' provide details below)

Abnormal Heart Condition	Y/N	Fainting Spells or Dizziness	Y/N	Palpitations	Y/N
Acne	Y/N	Glaucoma	Y/N	Psoriasis	Y/N
Alcohol Dependency	Y/N	Haemophilia	Y/N	Pregnant	Y/N
Alopecia	Y/N	Hair Loss (recent)	Y/N	Prolonged Bleeding	Y/N
Anaemia	Y/N	Hay fever	Y/N	Protruding or Varicose Veins	Y/N
Artificial Heart Valves / Joints	Y/N	Healing Problems	Y/N	Prosthetic Hip or Joint	Y/N
Blurred Vision	Y/N	Heart Murmur	Y/N	Rheumatic Fever	Y/N
Bruise or Bleed Easily	Y/N	Hepatitis	Y/N	Scar Easily	Y/N
Cancer	Y/N	High Blood Pressure	Y/N	Seizures	Y/N
Cataracts	Y/N	HIV or AIDS	Y/N	Sensitivity to Cosmetics	Y/N
Chapped Lips	Y/N	Hormonal Changes	Y/N	Spider veins (Telangiectasia)	Y/N
Circulatory Problems	Y/N	Hyperpigmentation	Y/N	Stomach Ulcers	Y/N
Cold Sores (herpes simplex)	Y/N	Hypertension	Y/N	Stroke	Y/N
Dermatitis or other skin sensitivity	Y/N	Hypertrophic Scars	Y/N	Thyroid Abnormalities	Y/N
Diabetes	Y/N	Keloid Scars	Y/N	Trichotillomania	Y/N
Dry Eyes	Y/N	Kidney Disease	Y/N	Tuberculosis	Y/N
Eczema	Y/N	Liver Disease	Y/N	Tumours, Growths or Cysts	Y/N
Epilepsy	Y/N	Low Blood Pressure	Y/N	Watery Eyes	Y/N
Eye Infection	Y/N	Mitral Valve Prolapse	Y/N		

Have you had any of the following? (please indicate Y/N, if 'Yes' provide details below)

Accutane (within last 6 months)	Y/N	AHA preparations (within last 2 weeks)	Y/N	Botulinum Toxin Injections	Y/N
Cortisone (within last 6 months)	Y/N	Other Tattoos	Y/N	Pacemaker	Y/N
Eyelash/Eyebrow Tint	Y/N	Chemical or laser peel (within 6 months)	Y/N	Collagen Injections	Y/N
Eyelid Surgery	Y/N	Retin-A (within 6 months)	Y/N	Contact Lenses	Y/N
Fat Transfer Injections	Y/N	Gore-Tex Implants/Silicone Injections	Y/N	Use of Sun bed	Y/N

I have read and fully understood the above information.

Client name	Signature	Date

Technician name	Signature	Date