blümin

COSMETIC TATTOO

CONFIDENTIAL CLIENT HISTORY FORM

WWW.BLUMINCOSMETICTATTOO.COM.AU
HELLO@BLUMINCOSMETICTATTOO.COM.AU

ABOUT YOU

Date:

E-mail:

Client Name:

Mobile Phone:

Date of Birth:

Emergency Name/Contact:

Address:

Referred by:

Suburb: Post Code:

How did you hear about us?:

Medication, including some supplements, can affect the healing and colour outcome of your procedure. It is important to be completely honest and detailed if you are taking any medication, or if any of the following applies to you:

ABOUT YOUR HEALTH

DO YOU HAVE ANY OF THE FOLLOWING?

Condition			Condition		
Diabetes (Type 1 or 2)	Yes	No	Keloid Scarring	Yes	No
Epilepsy	Yes	No	Moles on the area	Yes	No
High Blood Pressure	Yes	No	Alopecia	Yes	No
Heart Problems	Yes	No	Eczema/ Dermatitis	Yes	No
Blood Clotting issues	Yes	No	Hyperpigmentation	Yes	No
Hepatitis	Yes	No	Anxiety	Yes	No
Herpes Simplex	Yes	No	Thyroid Disorders	Yes	No
Liver Disease	Yes	No	Autoimmune Disorders	Yes	No
Rosacea	Yes	No	Sunburn (2 weeks)	Yes	No
Trichotillomania	Yes	No	Immunodeficiency Virus	Yes	No
Anaemia	Yes	No	Other	Yes	No

Do you have any allergies? Yes No

Details:

Are you pregnant or breastfeeding? Yes No

Are you currently planning/trying to conceive? Yes No

Do you smoke? Yes No

Have you consumed alcohol in the past 24 hours? Yes No

IN THE LAST SIX MONTHS?

Recent Surgeries: Yes No *Date:*

Details:

ABOUT YOUR SKINCARE

Do you have any current skin concerns? Yes No

Details:

Do you have any existing cosmetic tattoos? Yes No

Details:

IN THE LAST SIX MONTHS?

Facial Laser/IPL: Yes No

Notes:

Facial Fillers: Yes No

Notes:

Muscle Relaxants: Yes No

Notes:

Chemical Peels: Yes No

Notes:

DOES YOUR CURRENT SKIN CARE CONTAIN ANY OF THE FOLLOWING COSMECEUTICAL INGREDIENTS:

AHA's (Alpha Hydroxy Acids) including glycolic and lactic acids Yes No

BHA's (Beta Hydroxy Acids) including Salicylic Acid Yes No

Vitamin A (Tretinoin/Retinoic Acid/Retinol) Yes No

Vitamin C (Ascorbic Acid) Yes No

Benzoyl Peroxide Yes No

Hydroquinone/ Kojic Acid Yes No

THERAPIST NOTES

Machine		Pigment Range / Colours	
Needle / Code		Skin Tone / Fitz	
Comments		Follow Up	
Artist's Name			

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FITZPATRICK SCALE FOR SKIN-TYPE CLASSIFICATION

SKIN TYPE	SKIN COLOUR	HAIR COLOUR (darkest)	EYE COLOUR (most common)	DESCRIPTION
I	White or very pale	Blonde	Blue, Grey, Green	Always burns, never tans
II	Pale White with beige tint	Chestnut or Dark Blonde	Blue	Always burns, sometimes tans
III	Beige to light brown (olive)	Dark Brown	Dark Brown	Sometimes burns, always tans
IV	Light to moderate brown	Black	Brown	Rarely burns, always tans
V	Medium to dark brown	Black	Brownish Black	Rarely burns, tans more than average
VI	Dark brown to black	Black	Black	Never burns

YOUR SKIN TYPE

WHAT IS YOUR SKIN TYPE?

- Dry ◯ *Yes*
- Oily ◯ *Yes*
- Combination ◯ *Yes*
- Normal ◯ *Yes*
- Scarring (on the area) ◯ *Yes*

ABOUT YOUR MEDICATION

ARE YOU TAKING ANY OF THE FOLLOWING?

Opioid Medication (Endone, Methadone, Tremadol, Oxycontin)	◯ *Yes*	◯ *No*	*Notes:*
Chemotherapy/ Radiation Therapy	◯ *Yes*	◯ *No*	*Notes:*
Tamoxifen	◯ *Yes*	◯ *No*	*Notes:*
Prednisone	◯ *Yes*	◯ *No*	*Notes:*
Thyroxine	◯ *Yes*	◯ *No*	*Notes:*
HRT	◯ *Yes*	◯ *No*	*Notes:*
Roaccutane/Accutane (within 12 Months)	◯ *Yes*	◯ *No*	*Notes:*
Antibiotics / Doxycycline	◯ *Yes*	◯ *No*	*Notes:*
Prescription Vitamin A	◯ *Yes*	◯ *No*	*Notes:*
Warfarin/ Heparin/ Blood Thinners	◯ *Yes*	◯ *No*	*Notes:*
Other Medication	◯ *Yes*	◯ *No*	*Notes:*
Vitamins / Fish Oils or Herbs	◯ *Yes*	◯ *No*	*Notes:*

EYELINER TATTOO ONLY

Are you wearing contact lenses? *PLEASE REMOVE*	◯ *Yes*	◯ *No*	
Have you had any eye surgery?	◯ *Yes*	◯ *No*	*Notes:*
Are you using lash enhancing serums?	◯ *Yes*	◯ *No*	*Notes:*
Do you/have you had glaucoma?	◯ *Yes*	◯ *No*	*Notes:*
Do you have cataracts?	◯ *Yes*	◯ *No*	*Notes:*
Do you have dry eyes?	◯ *Yes*	◯ *No*	*Notes:*
Any recent/current eye infections?	◯ *Yes*	◯ *No*	*Notes:*

RISKS ASSOCIATED WITH SEMI-PERMANENT TATTOO PROCEDURE

I understand that all semi-permanent procedures carry with them the possibility of complications and consequences including but not limited to fading of skin pigments, risk of infection, scarring, eye damage, inconsistent colour and bruising. If I would like the best results from the procedure then I will need to follow after-care instructions and book in for a 4-8 week follow up.

I have been informed that colour may vary as the skin heals. I have advised my provider if I am susceptible to cold sores. I understand that having a lip procedure may inflame cold sores, especially if I suffer from cold sores. I have consulted with a doctor and received treatment prior to any lip procedures if I am susceptible to cold sores. I have received detailed instructions for the aftercare of my treatment and I will strictly adhere to these instructions. I understand that this treatment is for cosmetic purpose only. That no guarantees have been made to me regarding the results, I am responsible for the after care using only the aftercare advice provided, if not I may have risk of infection or fading of pigments if not carried out fully. The general nature of tattooing as well as the specific procedure to be performed has been explained to me. I understand that I cannot donate blood for 6 months after the treatment.

I understand that the provider of this procedure takes no responsibility for any possible complications and consequences that may result from the procedure, particularly if I neglect to answer these questions properly, if I fail to accurately disclose my medical history or if I fail to take pre-procedure and or aftercare treatment. I will not hold the therapist responsible in the event of any damage and shall not be entitled to take action against him/her at Law or Equity for such treatment. I consent to before and after photographs of this procedure, which is at the therapist's discretion. I consent to the therapist applying the topical anaesthetic products containing Lidocaine, Tetrocaine, Benzocaine, Epinephrine to the treatment areas and reapplying where necessary. I am over the age of 18 years old. I am not pregnant. I have answered truthfully to all above questions on this form. If I experience any changes, reactions or concerns after my treatment I will notify my therapist immediately for further consultation.

Client Signature: ______________________ Date: ____________