SAULER INSTITUTE OF TATTOOING

MEDICAL FORM

Name_____ DOB_____

Address_____City, State, Zip_____

Telephone (H)_____ Telephone(W)_____ Hair Color_____

Eye Color_____ (Cell)_____Text Msgs?YES / NO Email_____

How did you hear about us?_____

MEDICAL HISTORY: Please circle and explain if you have ever had or currently have:
Heart conditions, MVP, Pacemaker, Allergies to makeup, Accutane treatment, Dry eyes, Blepharitis, Keloid or hypertrophy scars, Diabetes, Stroke, Chest pains, Shortness of breath, Alopecia, Epilepsy, Seizures of any kind, Autoimmune disorders, Refractive disorders, Refractive eye surgery, Glaucoma, Hepatitis, jaundice, HIV, Joint replacement, Tendency to bleed excessively, Hyper-pigmentation, Hypo-pigmentation, Ocular herpes, Hepatitis A, B, C, Gortex implants, High/Low Blood pressure, Neck/Back pain, Antibiotics before invasive procedures, Trichotillomania, Cancer (any type).

Allergies/kind:_____

Current Medications:_____

Physician:_____ Phone:_____

___YES___NO Are you under the age of 18? Legal guardian's initials _____
___YES___NO Have you had any aspirin or blood thinning products in the last 7 days?
___YES___NO Have you had any non approved drugs within the last 8 hours?
___YES___NO Do you have any history of cold sores, herpes or fever blisters?
___YES___NO Are you sensitive to Latex?
___YES___NO Do you have any problems with healing?
___YES___NO Have you had a chemical or laser peel? If so, when? _____
___YES___NO Have you had any previous problems with tattoos?
___YES___NO Has your physician advised not to have a tattoo at this time?
___YES___NO Are you currently undergoing radiation or chemotherapy?
___YES___NO Are you currently using Retin-A or Alpha Hydroxy skin care products?
___YES___NO Do you wear contact lenses? (I*f yes, I understand they must be removed during my eyeliner procedure and should not be replaced until the next day*)
___YES___NO Have you ever had any permanent makeup procedures before?
___YES___NO Are you allergic to topical antibiotic preparations or desensitizers? (*e.g. Polysporm, Bacitracin, Neosporin or "Cane" family of drugs or Petroleum*)
___YES___NO Is there any history of skin diseases or remarkable skin sensitivities?
___YES___NO Are you presently taking A or E in any form?
___YES___NO Are you pregnant or nursing?

Signature:_____ Date:_____

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