We Love By Carolina, LLC
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Medical History Permanent Makeup & Microblading

Contact Information

Name: _____DOB: _____ Age: _____ Sex: _____
Address:_____City: _____ State: _____ Zip:_____
Phone:_____Email:_____ ❒ text ❒ call Occupation: _____

Procedures Desired: ❒ eyeliner ❒ eyebrows ❒ lip line ❒ full lip color ❒ nipples ❒ beauty mark ❒ skin repigmentation ❒ other: _____

Have you **ever** had cold sores or fever blisters? If yes, when was your last breakout?
❒ no ❒ yes; _____ If yes, you must contact your physician for a prescription of ZOVIRAX capsules, an antibiotic which prevents cold sores.
I have read the above information regarding ZOVIRAX and understand its use is mandatory if I desire lipline or full lip color procedures.

Client Signature: _____ Date: _____

Medical History

- Are you under the care of a physician? ❒ no ❒ yes
  - Physician Name: _____
- Do you take antibiotics when going to the dentist? ❒ no ❒ yes
- Are you pregnant or lactating? ❒ no ❒ yes; *please consult your physician.****
- Do you wear contact lenses? ❒ no ❒ yes

Do you have or have previously had any of the following conditions?

❒ no ❒ yes - History of MRSA
❒ no ❒ yes - Botox
❒ no ❒ yes - Diabetes
❒ no ❒ yes - Hepatitis A B C D
❒ no ❒ yes - Forehead/brow lift
☒ no ❒ yes - Easy bleeding
❒ no ❒ yes - Facelift
❒ no ❒ yes - Alchoholism
❒ no ❒ yes - Abnormal Heart Condition
❒ no ❒ yes - Take medication before dental work
❒ no ❒ yes - Chemical Peel (Last Treatment)
❒ no ❒ yes - Brow Lash Tinting
❒ no ❒ yes - Autoimmune disorder
❒ no ❒ yes -Oily Skin
❒ no ❒ yes -Cancer (Year)
❒ no ❒ yes - Accutane or acne treatment

❒ no ❒ yes -Chemotherapy/ Radiation
❒ no ❒ yes - Tan by booth or salon
❒ no ❒ yes -Tumors/ Growth/ Cysts
❒ no ❒ yes - Difficulty numbing with dental work
❒ no ❒ yes -Taking blood thinners such as: Aspirin, Ibuprofen, Alcohol, Coumadin etc
❒ no ❒ yes - Allergic reaction to any medications such as Lidocaine, Tetracaine, Epinephrine, Dermacaine, Benzyl Alcohol, Carbopol, Lecithin, Propylene Glycol, Vitamin E Acetate, etc
❒ no ❒ yes -Allergies to metals, food, etc
❒ no ❒ yes -Any diseases or disorders not listed
❒ no ❒ yes - Do you use skin care products containing Retin-A, Glycolic Acid, or Alpha Hydroxyl?
Please list any medications you are taking:_____

Thank you for your business!