MICROPIGMENTATION CONSULTATION SHEET

Client name:_____

Address:_____

Phone:_____DOB_____

Date: _____

Dr's name: _____ Phone: _____

Address: _____

Client's occupation:_____Hobbies: _____

*This information to be checked during consultation by the micropigmentation specialist.*

Relevant medical history and lifestyle notes.

| | | | | | |
|---|---|---|---|---|---|
| Allergies (eg anaesthetics, hair dye, nuts, metals, latex, food, medication) | Yes | No | Viral infections especially cold sores (Herpes zoster / simplex) warts | Yes | No |
| Bacterial infections (eg impetigo) | Yes | No | Eye infections (eg conjunctivitis) | Yes | No |
| Fungal infections (eg tinea, athletes foot) | Yes | No | Watery eyes | Yes | No |
| Severe skin conditions | Yes | No | Cuts or abrasions | Yes | No |
| Severe acne | Yes | No | Swelling / undiagnosed lumps | Yes | No |
| Irritation | Yes | No | Recent scar tissue | Yes | No |
| Eczema / Psoriasis | Yes | No | Bruising | Yes | No |
| Hyperkeratosis | Yes | No | Hypersensitive skin | Yes | No |
| Botox/dermal fillers | Yes | No | Respiratory conditions (asthma) | Yes | No |
| Claustrophobia | Yes | No | Sunburn | Yes | No |
| Recent surgery | Yes | No | Chemotherapy/cancer treatment in last year | Yes | No |
| Trichotillomania | Yes | No | Glaucoma | Yes | No |
| Dry eye syndrome | Yes | No | Thyroid imbalances | Yes | No |
| Alopecia | Yes | No | Parasitic infections (scabies, pediculosis) | Yes | No |
| Cancer | Yes | No | Boils | Yes | No |
| Have you had alcohol in last 2 days | Yes | No | Pregnant /breastfeeding | Yes | No |
| Have you taken painkillers in the last 2 days | Yes | No | HIV / AIDS | Yes | No |
| Keloids | Yes | No | Hyperpigmentation | Yes | No |
| Coronavirus | Yes | No | Tattoos | Yes | No |
| Hepatitis | Yes | No | Seizures or epilepsy | Yes | No |
| Heart condition | Yes | No | Prolonged bleeding | Yes | No |
| Use of Retin A or Retinol | Yes | No | Contact lenses | Yes | No |
| Thyroid or hormonal issues | Yes | No | Use of sunbed or recent sun exposure | Yes | No |
| Do you take any regular medication? Please list any medications you are currently taking. | | | | Yes | No |
| Have you ever had a dental injection to numb your gums | | | | Yes | No |
| Prior to dental procedures do you receive antibiotic medication? | | | | Yes | No |
| Difficulty with breathing or rapid heartbeat with a dental injection | | | | Yes | No |
| Do you have an MRI scan scheduled in the next 3 months | | | | Yes | No |
| Laser or IPL hair removal close to the treatment area in the past or future | | | | Yes | No |

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| | | |
|---|---|---|
| Any condition presently under supervision of a doctor/dermatologist/medical professional.<br><br>Please give details. | Yes | No |
| Current skin care routine, and make-up products used: | | |
| Reason for service / desired outcome: | | |

Patch test date: _____ Products tested: _____

Result of patch test: _____

Skin analysis:

| | | | | | |
|---|---|---|---|---|---|
| *Skin type* | Normal | Dry | Oily | Combination | |
| *Skin condition* | Sensitive | Dehydrated | Mature | Broken capillaries | Papules |
| | Open pores | Dark circles | Pigmentation | Scarring | Erythema |

| Treatment / service | Tools / products used | Advice given / comments |
|---|---|---|
| | | |

Client signature for permission to treat and take
before / after images for use on social media: _____

I confirm that I have read the pre-treatment advice and have been given the aftercare advice leaflet.

Name: (Print) _____ Signature: _____

Micropigmentation specialist signature: _____

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