PRE-SCREENING QUESTIONNAIRE

1) Are you pregnant or nursing? **Y/N**

2) Are you prone to keloid scarring, hypertrophic scarring or any other form of excessive scarring condition? **Y/N**

3) Have you taken any medication containing Isotretinoin (e.g Roaccutane) within the last 12 months? **Y/N**

4) Have you been using any unapporved, experimental or illegal medications and/or treatments on your skin? **Y/N**

5) Do you have, or is it possible you have, any blood borne communicable disease? (e.g HIV/AIDS, Hepatitus C, Hepatitus B) **Y/N**

6) Do you have any other form of communicable disease or infection? (e.g gastrointestinal infection, respitory infection, skin infection, ear or eye infection, bacterial, fungal or viral infection) **Y/N**

7) Are you currently on any form of immunosuppressant therapy, or have another conditions that may cause delayed healing? **Y/N**

8) Do you have hypersensitivity, auto-immune disorder, or any allergic conditions? **Y/N**

9)Do you have a known allergy or sensitivity to any topical or local anesthetics (including dental anesthetics)? **Y/N**

10) Do you have any form of bleeding disorder, or are you taking any anticoagulants (blood thinners)? **Y/N**

11) Have you had any form of procedure (cosmetic or surgical), radiotherapy or chemotherapy at any time within the last 6 months? **Y/N**

12) Do you suffer from any form of hyper-pigmentary skin condition? **Y/N**

13) Do you suffer from seizures, fainting and/or blackouts? **Y/N**

14) Do you have a heart condition or abnormal blood pressure? **Y/N**

15) Are you prone to developing telangiectasia (also referred to as spider veins)? **Y/N**

16) Are you 18 years or older? **Y/N**

17) Have you or any memeber of your household had any form of skin infection within the last 12 months? **Y/N**

18) Do you have an allergy or sensitivity to latex or rubber? **Y/N**

19) Do you have any known allergy or sensitivity to any ingredients in tattoo pigments ro needles, regular makeup, hair dyes or other dyes? **Y/N**

20) Do you have any known allery or sensitivity to ingredients in tattoo aftercare creams, antiseptics, lanoline or petrolatum (patroleum jelly)? **Y/N**

21) Have you used any eyelash/eyebrow growth creams/serums or eye drops that contain prostagladin analogues in the past 4 weeks? **Y/N**

22) Do you have any other medical condition not stated above? **Y/N** If yes, please state the medical condition

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23) Are you taking any medications not stated above? **Y/N** If yes, please stat the type of medication

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Makeup artist notes:

Name: _____ Signature:

_____

Date: _____