LAURA McELROY BEAUTY LLC

Waxing • Makeup • Lash & Brow

www.lauramcelroybeauty.com (605) 370-1577

Today's Date _____/_____/_____

Name _____ Date of Birth _____/_____/_____ Email: _____

Ethnic Background, please include all nationalities _____

Address _____Apt. # _____City:_____

State _____ Zip _____ Home Phone (_____)_____ Cell (____)_____

Occupation: _____ If we call you at home, do you want confidentiality? No Yes

May we call you at work? No Yes If Yes, my work number is (_____)_____

Emergency Contact, Name _____ Phone (_____)_____Relationship_____

Who may we thank for referring you? _____

Procedure(s) desired: Brows Eyeliner Lips Camouflage Areola Complex Correction

List all medications you are presently taking

Name of drug	Mg. or mcg.	How many ea. day	Why it was prescribed to you

List all medications you took in the last six months that you are no longer taking:

Name of drug	Mg. or mcg.	How many ea. day	Why it was prescribed to you

Practitioner Signature _____ **Date** _____/_____/_____

GENERAL MEDICAL ClientName: _____

Do you have? (check all that apply)

Fever Blisters/Cold Sores (Ever, even one time)

Glaucoma or other eye disease/disorder

Grave's Disease

Heart Disease

Shingles History/ Recent Shingles Shot

Mitral Valve Prolapse

Valve Implants

Pacemaker

Stents

Diabetes requiring insulin

Problems with healing

Keloids

Seizures

Dermatological Disorder
If so, what? _____

Active or in Flare-ups? _____

Hemophilia or Clotting Disorder

Autoimmune Disorder

Pre-existing nerve damage

Tattoos: Colors you are sun sensitive to:

_____

Trichotillomania (pulling of hair, brows, lashes)

Alopecia Totalis or Areata

Allergies
List: _____

Do you use? (check all that apply)

Accutane (currently or within the past year)

Antibiotics prior to dental procedures

Steroids

Retin-A, Glycolic Acid, Vitamin C or other Exfoliants

Tanning Beds

Eyebrow Tinting

Eyelash Tinting

Latisse

Botox When_____

Chemical Peels When_____

Chemotherapy or Prophylactic dose of Chemotherapy

Blood Thinners

Have you had? (check all that apply)

Fever Blisters/Cold Sores (Ever, even one time)

Eye Infections (Are you prone to them)

Vision Correction Procedure (Lasik, RK) within the past 3 months

Heart Attack - When? _____

Joint Replacement, Organ Transplant

Eye Trauma

Seizures

Fainting Spells

Hepatitis - What Type: _____

Hepatitis Test - When? _____

Fat Transfer Injections - If yes, where? _____

Gore-Tex Implants - If yes, where? _____

Aesthetic or Cosmetic Procedures
If yes, where? _____

Laser Treatments

What type & why? _____

Are you? (check all that apply)

Pregnant
Planning cosmetic surgery
If so, what & when? _____
Currently under the care of a physician
Describe: _____

Do you practice outdoor activities? Circle all that apply

Tennis	Swimming
Golf	Skiing
Gardening	Walking
Boating	Other

Physician's Name:_____
Address: _____
Phone: _____
Specialty: _____

Signature of Practitioner _____ Date ____/____/_____

INFORMED CONSENT TO PROCEDURE

1. Are you pregnant or nursing?

   Yes [] No []

Initial

2. _____ I absolutely understand and accept that such procedure is a process, often requiring multiple applications of color to achieve desirable results and the 100% success cannot be guaranteed.

3. _____ I have received, reviewed and understand the pre-procedural instructions as given to me and agree to follow them.

4. _____ Depending on the procedure(s), which I select, I accept responsibility for determining the shape, and position of eyebrows, eyeliners, lipliner and/or full lip color.

5. _____ I understand that the color selection and color results in all procedures are not an exact science.

6. _____ I understand that positioning of my procedures can be affected if I have elected or wish to elect cosmetic surgery, Botox or Restalyne and I assume this responsibility. .

7. _____ I am aware that if I am to receive an MRI after the procedure, I must tell the Radiologist that I have iron oxide permanent cosmetics.

8. _____ If I am a lens wearer, I realize that I must keep my lenses out the day of an **eyeliner procedure**.

9. _____ I understand that this procedure will fade and this fading can alter the original pigment color and that this determines that it is a time for a touch-up visit.

10. _____ I realize this is an elective cosmetic procedure and is not medically necessary.

11. _____ It has been explained to me that the following possibilities may occur: Minor and temporary bleeding, bruising, redness or other discoloration; swelling; fever blisters on the lip area following lip procedures and/or fading or loss of pigment.

12. _____ I understand that many lasers & IPL's (Intense Pulse Lights) including those used for hair removal, anti-aging, Photo Facials, removal of lines may or will turn permanent make up dark or even black. I agree to inform my esthetician or anyone operating such that I have permanent make up.

13. _____ I give my consent to **Laura McElroy Beauty, LLC** to confer with my physicians for medical information required for the safety of my procedures.

14. _____ I agree to accompany my practitioner to the emergency room in the event they were to be accidentally stuck with my needle and take a blood test for their safety & disclose all test results to my practitioner.

15. _____ I am aware that if an infection occurs after I have received Permanent Cosmetics to see with my primary physician or an emergency room, ***immediately***.

16. _____ I have fully and truthfully informed Laura McElroy Beauty, LLC that I am free from any communicable diseases such as Hepatitis B, Human Immunodeficiency Virus Infection, or any other infectious diseases or skin lesions.

ACCEPTANCE:

I have read and understand these risks listed above and they have been explained to me. I certify that the information in the above questionnaire is accurate and my questions have been answered.

*****Please read all questions thoroughly before signing!!***

Signature of Client X_____

Signature of Practitioner _____**Date** _____/____/_____