Nano/Micro Needling Treatment
Confidential Medical Profile

Client Name:_____

Today's Date:_____

Date of Birth:_____

Address:_____

Allergies:_____

Please circle the answer that applies:

YES NO	Are you under the age of 18?
YES NO	Are you pregnant or nursing?
YES NO	Have you had any blood thinning medications in the last 7 days?
YES NO	Have you had any mood altering medications in the last 24 hours?
YES NO	Do you have a history of herpes, cold sores, or fever blisters?
YES NO	Do you have a history of skin disorders or remarkable skin sensitivities?
YES NO	Do you have problems with healing?
YES NO	Have you had any permanent makeup procedures before?
YES NO	Have you had any previous problems with tattoos/permanent makeup?
YES NO	Are you currently undergoing chemotherapy or radiation?
YES NO	Are you currently using Retin-A or alpha-hydroxy skin care products?
YES NO	Have you had a photofacial or laser rejuvenation in the last 30 days?
YES NO	Do you wear contacts?
YES NO	Are you using any lash conditioners/growers or serums?
YES NO	Do you use nicotine on a daily basis?
YES NO	Do you have a history of keloid scarring?

Please circle all the applies:

Heart Disease	Alopecia	Kidney Disease	Trichotillomania
Hepatitis	Dry Eye	HIV	Autoimmune Disorder
Cancer	Keloids	Diabetes	Hyper-pigmentation
Epilepsy	Stroke	Bleeding Disorder Cold	Hypo-pigmentation
Glaucoma	Herpes	Sores/ Fever Blisters	

Please list any and all medications you are currently taking

_____

Practitioner makes no attempt to or claim to practice medicine. Some individuals will have complications related to permanent makeup application. These complications are usually mild and last only a few days. However, extreme complications are always a possibility. By signing this consent you are acknowledging that you are in good health and there are no apparent reasons to restrict you from receiving esthetic services.

Client Signature_____ Date_____

Informed Consent

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY AND INDICATE THAT YOU UNDERSTAND AND ARE IN AGREEMENT WITH EACH STATEMENT BY PLACING YOUR INITIALS NEXT TO EACH ONE.

_____ 1. I understand and accept that no guarantee can be given as to the condition of my skin or degree of improvement expected following treatment.

_____ 2. I have received, reviewed and understand the written and verbal post procedural instructions as given to me and agree to follow them exactly.

_____ 3. I understand that before and after photographs may be taken and the rights to all photographs taken belong to LOTUS and therefore may be used in any way LOTUS chooses to do so.

_____ 4. I understand that multiple treatments and the use of recommended home skin care maintenance are required to achieve optimal results.

_____ 5. I will apply sunscreen that is at least SPF 30 or more 30 minutes prior to sun exposure.

_____ 6. I understand that in rare cases, allergies and/or sensitivities have been reported of products used during treatment.

_____ 7. I understand this is an elective cosmetic procedure that is not an exact science and is not medically necessary.

_____ 8. I understand that the following contraindications will prevent me from having treatments. It is my responsibility to fully disclose all pertinent medical history before the procedure and update my esthetician at all future sessions. I agree to disclose any of the following conditions PRIOR to signing this consent:

Infected skin disorder, active bacterial/fungal infection, active acne, open cuts, wounds/abrasions, keloid scars, eczema, psoriasis, chronic skin conditions, scleroderma, vascular diseases, cardiac abnormalities, cardiac
pacemaker, chemotherapy/radiation, chemical peel within 4 weeks prior to treatment, skin cancer in area to be treated, epilepsy, pregancy/lactation, sunburn/irritated skin, untreated sinusitis, uncontrolled diabetes.

_____ 9. Although the majority of individuals do not experience any complications, it is important to understand that risks exist. I understand that the following may occur; minor and temporary bleeding, redness/swelling, peeling and dryness, fever blisters/cold sores (for individuals who are prone to them).

_____ 10. I have disclosed all pertinent medical history, medications and allergies to ensure the safety of my procedure(s).

ACCEPTANCE: I have thoroughly read and understand this document. The risks involved with my procedure(s) have been verbally explained to me. I thoroughly understand all the written and verbal aftercare instructions. I certify that all of my questions have been answered and I accept full responsibility and agree to hold harmless Lotus and Robyn Liston for any complications that may arise during or following the procedure(s) to be performed at my request. I hereby release them from liability, both seen and unforeseen now and forever.

PRINT NAME:_____

CLIENT SIGNATURE:_____DATE:_____

ESTHETICIAN SIGNATURE:_____DATE:_____