



BELLA VIA
Skin and Body Therapies

Permanent Makeup Health and History Questionnaire

Name: _____ Date: _____

Address: _____ City/State: _____ Zip Code: _____

Phone: (Home) _____ (Work) _____ (Cell) _____

Date of Birth: _____ Referred By: _____

Email Address: _____ Occupation: _____

Procedure Desired: _____

- I, _____, am over the age of 18, am not under the influence of drugs or alcohol, am not pregnant or nursing, and desire to receive the indicated Permanent Makeup procedure.
- Do you wear contact lenses? Yes ____ No ____
If so, they must be removed during an eyeliner procedure and should not be worn until the following day.
- Do you have any tattoos? Yes ____ No ____
- Have you ever had any Permanent Makeup procedures? Yes ____ No ____
If yes, please specify _____
- Do you have any kinds of heart conditions? Yes ____ No ____
If yes, please specify _____
- Are you a diabetic? Yes ____ No ____
- Are you presently taking any medications, including any immunosuppressive, such as an anti-inflammatory, or steroids? Yes ____ No ____ If yes, which medications? _____

- Are you able to take over-the-counter antihistamines? Yes ____ No ____
- Are you allergic to topical antibiotic preparations (i.e. Polysporin, Bacitracin, Neosporin)? Yes ____ No ____
- Are you allergic to any metals? (i.e. you can only wear 14K gold earrings) Yes ____ No ____
- Do you have any other allergies? Yes ____ No ____
If yes, please specify _____
- Have you ever had a fever blister, cold sore (herpes), or canker sore? Yes ____ No ____
If yes, you must consult with and strictly follow your doctor's instructions before contemplating any Permanent Makeup procedure.
- Are you using Retin-A, retinol, glycolic acids, or any exfoliating products? Yes ____ No ____



Affiliated with Reconstructive &
Aesthetic Surgeons, Inc.
419.534.6551 • www.RASInet.com

Craig W. Colville, M.D., F.A.C.S.
John F. Zavell, M.D., F.A.C.S.



BELLA VIA
Skin and Body Therapies

Permanent Makeup Health and History Questionnaire

- Are you taking Vitamin E or Aspirin regularly? Yes ____ No ____
- Do you have a history of skin diseases or skin sensitivities? Yes ____ No ____
If yes, please specify _____
- Check any of the following pertaining to you:

Contagious Diseases	____	Port Wine Hemangiomas	____	Hepatitis	____
Keloids	____	A.I.D.S.	____	Scleroderma	____
Respiratory Problems	____	Excessive Aspirin use	____	Glaucoma	____
Menstrual	____	Hemophilia	____	Pregnant	____
High Blood Pressure	____	Allergies	____	Diabetes	____
Hyperpigmentation	____	Lupus	____	Heart Problems (any)	____
Other	_____				
- Have you had any type of surgery within the last 2 years? Yes ____ No ____
If yes, please explain _____

Client Signature: _____ Date: _____

Technician Signature: _____ Date: _____

