



**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 \_\_\_\_



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- 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: \_\_\_\_\_

