

FoxWest Medical & Aesthetics

Permanent Cosmetics Consultation Form

Name _____
 Address _____ City _____ State _____ Zip _____
 Home Phone (____) _____ Work Phone (____) _____ Cell #(____) _____
 Occupation _____ Employer _____
 Email Address _____ How did you hear about FaceWurks?: _____
 Birthdate _____ M/F Age 18-25, 26-35, 36-45, 46-55, 56-65, 66-75, 76+
 What areas are you interested in today? _____ In the future? _____

Are you currently using any of the following? (please circle Yes or No)

Aspirin	Y/N	Blood Pressure	Y/N
Cortisone	Y/N	Steroids	Y/N
Hormones	Y/N	Insulin	Y/N
Arthritis	Y/N	Tranquilizers	Y/N
Blood Thinning	Y/N	Antibiotics	Y/N
Retin A/Glycolic/Accutane	Y/N	Antidepressants	Y/N

Have you ever experienced any of the following? (please circle Yes or No)

Cancer	Y/N	Anemia	Y/N
Dry Eyes	Y/N	Fainting	Y/N
Vision problems	Y/N	Heart condition	Y/N
Sinus/Hay fever/Allergies	Y/N	Chest pain	Y/N
Migraines	Y/N	Artificial Joints	Y/N
Seizures	Y/N	Rheumatic Fever	Y/N
Glaucoma	Y/N	Diabetes	Y/N
High Blood Pressure	Y/N	Breast problems	Y/N
Currently Pregnant	Y/N	Jaundice	Y/N
Hemophiliac	Y/N	Tested for Aids	Y/N
Asthma	Y/N	Collagen Injections	Y/N
Plastic Surgery	Y/N	Scarring	Y/N
Blood Transfusion	Y/N	Dermabrasion	Y/N
Hepatitis	Y/N	Chemical Peel	Y/N
Alopecia	Y/N	Herpes	Y/N
Hyperthyroid	Y/N	Fever Blisters	Y/N
Mental Disease	Y/N	Cold Sores	Y/N

Do you have any condition(s) or taking any drugs not listed? _____

Do you have any allergies not listed? _____

Have you had facial, back, neck or chest surgery? _____

How would you like your permanent cosmetics to look? _____

Comments or Concerns? _____

Signature _____ Date _____