BELLA VIA
Skin and Body Therapies

PERMANENT MAKEUP INTAKE FORM

Name:____ DOB:______________ Age:________ Gender:____________

Address:______________________________________ City:_______________ State:________ Zip Code:__________

Home Phone:________________________ Cell:____________________________ Work: ______________________

Email Address:____Occupation: __________________________
(Your email address will be used for appointment confirmations, quarterly newsletters, and to alert you of specials and promotions.)

How were you originally referred to Bella Via? (Please circle and add note if applicable.)
Dr. Colville Dr. Zavell Website Friend: ________________________________
Other: ____

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 ____
- 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: ____________________

Thank you for visiting Bella Via!

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