



BELLA VIA
Skin and Body Therapies

Microblading/Shading 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 Dr. Khan 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 ____

• 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 ____
- Have you had Botox Injections? Yes ____ No ____ If yes, please note the last treatment date and the area treated. _____
- Have you had Filler Injections? Yes ____ No ____ If yes, please note the last treatment date and the area treated. _____
- 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	____	Pregnant	____
Menstrual	____	Hemophilia	____	Diabetes	____
High Blood Pressure	____	Allergies	____	Heart Problems (any)	____
Hyperpigmentation	____	Lupus	____	Menopause	____
Alopecia	____				
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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