FANTASTIC
I LASH

Client Personal Record & Medical History

Name : _____

Address : _____

Email: _____

Phone : (H) _____ (W/C) _____

Occupation : _____

Date of Birth : _____ Sex : _____

MEDICAL HISTORY (please mark Y for "yes" or N for "no")

Allergies _____ Keloid Scars_____ Diabetes _____ Cold Sores/Shingles_____
Hemophilia _____ Hypoglycemia_____ Aids (Hiv)_____
Pregnancy _____ Heart Problem_____ Cancer_____
Hepatitis /Jaundice_____ High Blood Pressure_____ Current Medication_____
Blood Thinner_____ Contact Lenses_____ Laser Treatment_____
Skin Peel_____
Botox _____ If yes, when did you last have Botox?_____ Are you planning more Botox? _____
Fillers _____ Do you plan to continue with Fillers? _____
Other _____
Do you have old permanent makeup ?_____Area_____When was it done_____

I acknowledge that any information contributed by me is true, to the best of my knowledge and that the present condition of the area that has been treated or will be treated is stated on this record. I fully understand that Fantastic I Lash only provides beauty services; there is no medical treatment involved.

I realize that with any beauty service there may be certain risks which must be understood. I will be fully responsible for any and all results which may arise from these beauty services. I do hereby agree to Fantastic I Lash, their employees and agents, free from any and all claims or suits for damage, for injuries or complications resulting from any beauty service provided by Fantastic I Lash.

The nature and purpose of the beauty services, the risks involved and the possibility of complications have been fully explained to me. I understand that no guarantee or assurance has been given by anyone as to the results that may be obtained.

By signing below I acknowledge that I have read and understand the above and all of my questions have been answered and that I consent to have the above beauty services.

Signature:_____
Date:_____