**Client Health History: Lash Extensions**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_Zip:\_\_\_\_\_\_\_\_\_\_

Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Would you like to receive exclusive specials & insider information from our eNewsletter? Yes / No

How did you hear of us?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency contact name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to you:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health History Please list any allergies you have (including cosmetics/ingredients): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you allergic to Acrylate/Cyanocarylate (bonding agent)? Yes/No/Don’t Know

Have you ever had a reaction to adhesive tape, topical creams, nail adhesives, or other topical products? Yes/No

Do you have any eye disease, condition or injury that has affected your hair/lash growth or loss? Yes/No

Please list all current medications you are taking (including over-the-counter herbs, vitamins and supplements):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Have you ever had any of these conditions? (Please circle)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Alopecia | Asthma | Back Pain or Back Injury | Bell’s Palsy | Blepharitis | Claustrophobia |
| Cold Sores | Conjunctivitis (pink eye) | Diabetes | Dry Eye Syndrome | Eye Sties or Sores | Herpes of the Eye |
| Intense Stress | Leamy Eye | Light Sensitivity | Migraines | Ocular Rosacea | Rosacea |
| Sensitive Eyes | Stroke/TIA | Thyroid Disease | Trichotillomania | Recent Eye Surgery | Current Eye Irritation |

Any other health condition not listed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**These questions are relevant to your hair growth, and overall hair health. Please answer as fully as possible.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Question | Yes | No | Detailsif Applicable | Adverse ReactionsIf Applicable |
| Are you pregnant or nursing? |  |  |  |  |
| Do you wear contacts? |  |  |  |  |
| Do you wear glasses? |  |  |  |  |
| Have you ever had lash extensions? |  |  |  |  |
| Have you ever had lash extensions removed? |  |  |  |  |
| Have you ever used long lasting or waterproof cosmetics? |  |  |  |  |
| Have you ever had facial injectables? |  |  |  |  |
| Have you ever used a lash growing product? |  |  |  |  |
| Do you use Retin-A or Accutane? |  |  |  |  |
| Do you go tanning (in salon, outdoor or spray tan)? |  |  |  |  |

Which side do you most often sleep on? \_\_Right \_\_Left \_\_Stomach \_\_

Back How fast do you feel your hair grows? \_\_Fast \_\_Slow \_\_Normal Rate

Is there anything else we should know about?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin and eyes from treatments received. The treatments I receive here are voluntary and I release this institution and/or skin care professional from liability and assume full responsibility thereof.

**Client Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_