



G R E G R U F F , M D

PERMANENT MAKEUP HEALTH HISTORY

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Today's Date \_\_\_\_\_

Patient Name \_\_\_\_\_
Last First Middle

Procedures Desired

- Eye brows, Lipliner, Eyeliner, Scar camouflage, Describe area to be covered

Eyes/Eyebrows

- Do you wear contact lenses?, Eye makeup sensitivities?, Do you have dry eyes?, Blurred vision?, Thyroid Abnormalities?, Glaucoma?, Alopecia Universalis?, Alopecia Areata (local)

Lips

- Cold sores, fever blisters, herpes around the mouth or chicken pox as a child?, Collagen, fat, or other lip enhancements?, Describe

Skin

- Accutane in the last year?, Do you use Retin-A, glycolic acid and AHA or had chemical peels?, Other tattoos, Thick or raised scarring?, Bruise or bleed easily?, Tanning habits, Other skin conditions

General Medical

- High blood pressure, Seizure disorders, Hepatitis, Blood thinners or anticoagulants such as alcohol, aspirin, ibuprofen or Coumadin, Heart Palpitations, Current cold, viral or allergy symptoms? Describe

Allergies

- Lanolin, Latex or rubber, Lidocaine, Foods, Bacitracin Ointment, Novocaine, PABA, Medications

List all surgical operations that you have had \_\_\_\_\_

Are you planning any cosmetic procedures, including surgery, laser resurfacing, photo rejuvenation or laser hair removal?

Describe \_\_\_\_\_

List all medications (including over the counter and homeopathic medicines) that you are currently taking.

If you are under a physician's care, please describe \_\_\_\_\_

Describe the procedures you are requesting and the desired results \_\_\_\_\_

- Fees discussed, Refund policy discussed, Patch test

I understand that Greg Ruff, MD and his technicians employ a no-refund policy. I have been offered a patch and sensitivity test, which is good for 30 days. It is understood that I have received or waived a patch test prior to application that releases Greg Ruff, MD and his staff from any liability related to allergic or other reactions to applied pigments (pigment contents: iron oxide, alcohol, distilled water and glycerin). I further understand that this procedure is a process and subsequent visits might be necessary to achieve the desired results. The fee discussed will include up to three treatments for the specified area. Treatments must be completed within 6 months. Any additional treatments will be charged at the rate of \$150/hour unless otherwise agreed upon. I acknowledge that no guarantees have been made to me concerning the results of this procedure. For the purposes of documentation, I also consent to the taking of before and after photographs. I accept full responsibility for complications that may arise from results during or following the cosmetic which is to be performed at my request according to this consent. I acknowledge that it is my responsibility to inform the doctor or technician of my permanent cosmetics in the event of an MRI procedure.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_