Mudwraps to Manicures Client Record

Last Name: _____ First Name: _____

Address: _____ City:_____ Province: ____ Postal Code: _____

Date of Birth: _____ Parental Consent: ☐Yes ☐NA Date: _____

PLEASE CIRCLE ANY CONDITIONS LISTED BELOW THAT APPLY TO YOU

TB	Epilepsy	Blood Thinners	Scarring/Keloiding
HIV	Asthma	Eczema/Psoriasis	Gonorrhea/Syphilis
Herpes	Hepatitis	Heart Condition	MRSA/Staph Infections
Diabetes	Hemophilia/other Bleeding Disorder	Pregnant/Nursing	Allergic Reactions To Latex
	Skin Conditions	Fainting Or Dizziness	Allergic Reactions To Antibiotics

How long has it been since you last ate? _____

Do you have any allergies? _____

Do you use any medications or have any medical/skin conditions that may affect the healing of the microblading you wish to receive? _____

Is there any information you feel you should provide to the aesthetician?

_____

_____

Procedure:

Microblading

Location of microblading: Eyebrow

Colors, Manufacturer, and Lot Numbers of all inks used:

_____

_____

_____

_____

Aesthetician Signature: _____ Client Signature: _____

Attach to this page copies of clients ID and any packaging showing lot numbers, date sterilized, etc. from all instruments or equipment used during this procedure.