PMU Medical Intake & Health Questionnaire

Client: _____

DOB: _____

Date: _____

Please answer all questions honestly. This information is used only to determine whether this procedure is safe for you. It is not shared with third parties.

Current Medications

List all current medications, supplements, and vitamins (include dosage if known):

_____

- **Are you taking any of the following?**
  - ☐ Blood thinners (aspirin, warfarin, clopidogrel, heparin, etc.)
  - ☐ Retinoids / Vitamin A derivatives (Accutane, Retin-A, tretinoin)
  - ☐ Oral corticosteroids
  - ☐ Immunosuppressants (methotrexate, cyclosporine, etc.)
  - ☐ Antibiotics (currently taking)
  - ☐ Other prescription medications: _____

Medical Conditions

Check all that apply:

☐ Diabetes (Type 1 or Type 2)

☐ Heart condition or pacemaker

☐ Autoimmune condition (lupus, rheumatoid arthritis, MS, etc.)

☐ Thyroid disorder

☐ Hemophilia or other bleeding/clotting disorder

☐ Hepatitis B or C

- [ ] HIV / AIDS
- [ ] Epilepsy or seizure disorder
- [ ] Chronic skin conditions (eczema, psoriasis, rosacea, vitiligo)
- [ ] History of keloid or hypertrophic scarring
- [ ] Active cancer treatment (chemotherapy or radiation)
- [ ] Cancer treatment completed within the last 12 months
- [ ] None of the above

Additional details about any checked conditions: _____

Pregnancy and Nursing

- **Are you currently pregnant?**
  - [ ] Yes
  - [ ] No
  - [ ] Unsure
- **Are you currently nursing/breastfeeding?**
  - [ ] Yes
  - [ ] No

PMU procedures are generally not recommended during pregnancy or while nursing. If you checked Yes or Unsure, please consult your healthcare provider before proceeding.

Allergies

- **Do you have known allergies to any of the following?**
  - [ ] Latex
  - [ ] Nickel or other metals
  - [ ] Tattoo or cosmetic pigments
  - [ ] Topical anesthetics (lidocaine, benzocaine, tetracaine)
  - [ ] No known allergies
  - [ ] Other: _____

Describe any past allergic reactions (what caused it, what happened):

_____

Skin and Prior Cosmetic Work

- **Do you have any of the following in or near the treatment area?**
  - ☐ Previous permanent makeup or microblading
  - ☐ Decorative tattoo
  - ☐ Scar tissue
  - ☐ Active breakout, cold sore, or wound
  - ☐ None of the above
- **Recent cosmetic procedures in the treatment area (past 4 weeks)?**
  - ☐ Botox or neuromodulator injection
  - ☐ Dermal filler
  - ☐ Laser treatment or chemical peel
  - ☐ None

Date of most recent procedure (if any): _____

Sun Exposure and Skincare

Describe your typical sun exposure and tanning habits (relevant to fading):

_____

- **Do you use any of the following on the treatment area?**
  - ☐ Topical retinol or vitamin A products
  - ☐ AHA / BHA / glycolic acid products
  - ☐ None of the above

Consent to Proceed

☐ I certify that I have answered all questions truthfully and to the best of my knowledge.

- [ ] I understand that withholding relevant health information may affect the safety of this procedure and that the artist/studio is not liable for complications arising from undisclosed conditions.
- [ ] I understand that if any of my answers indicate a potential contraindication, I may be asked to obtain medical clearance from my healthcare provider before proceeding.
- [ ] I understand that this questionnaire is a screening tool only and does not constitute medical advice or diagnosis.

Client Signature: _____ Date: _____

Artist/Staff Signature: _____ Date: _____