CONFIDENTIAL HEALTH QUESTIONNAIRE

NAME: _____
FIRST NAME: _____
DATE OF BIRTH: _____

Do you suffer from heart problem(s) such as: cardiovascular malformation, high blood pressure, or other? If yes specify:

Do you suffer from Hemophilia?

Do you suffer from herpes, even cold sores or “cold sores”?

Do you have HIV, Hepatitis B, Hepatitis C or a diagnosed STI?

Do you take anticoagulant medication?

Are you a recipient of blood transfusions?

Are you a blood donor?

Do you suffer from Shingles?

Do you suffer from Ichtosis?

Do you suffer from Eczema?

Do you suffer from Melanoma?

Do you suffer from Chléloides?

Do you suffer from Lupus?

Do you suffer from Psoriasis?

Do you suffer from poor healing?

Do you suffer from Alopecia?

Do you suffer from any other chronic skin disease? If yes specify:

Do you have allergies ? If yes, specify:

Do you suffer from Diabetes?

Do you suffer from an immune system disorder?

Do you suffer from Epilepsy?

Have you ever had a seizure, stroke or syncope episodes?

Have you had, or are you planning to have surgery? If yes, specify:

When:

Do you take aspirin daily?

In the past 24 hours, have you consumed alcohol or caffeine?

Have you ever received permanent/semi-permanent make-up or tattoo care?

I have understood and answered the above questions to the best of my knowledge with the truth and I understand that my answers could affect the process and/or the healing of my tattoo if they turn out to be wrong.

Signature: