

CONFIDENTIAL HEALTH QUESTIONNAIRE

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

	Yes	No
Do you suffer from heart problem(s) such as: cardiovascular malformation, high blood pressure, or other? If yes specify: _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you suffer from Hemophilia? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you suffer from herpes, even cold sores or "cold sores"? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have HIV, Hepatitis B, Hepatitis C or a diagnosed STI? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you take anticoagulant medication? _____	<input type="checkbox"/>	<input type="checkbox"/>
Are you a recipient of blood transfusions? _____	<input type="checkbox"/>	<input type="checkbox"/>
Are you a blood donor? _____	<input type="checkbox"/>	<input type="checkbox"/>

Do you suffer from Shingles? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you suffer from Ichthosis? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you suffer from Eczema? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you suffer from Melanoma? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you suffer from Chléloloides? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you suffer from Lupus? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you suffer from Psoriasis? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you suffer from poor healing? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you suffer from Alopecia? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you suffer from any other chronic skin disease? If yes specify: _____	<input type="checkbox"/>	<input type="checkbox"/>

Do you have allergies ? If yes, specify: _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you suffer from Diabetes? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you suffer from an immune system disorder? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you suffer from Epilepsy? _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a seizure, stroke or syncope episodes? _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you had, or are you planning to have surgery? If yes, specify: _____	<input type="checkbox"/>	<input type="checkbox"/>
When: _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you take aspirin daily? _____	<input type="checkbox"/>	<input type="checkbox"/>
In the past 24 hours, have you consumed alcohol or caffeine? _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever received permanent/semi-permanent make-up or tattoo care? _____	<input type="checkbox"/>	<input type="checkbox"/>

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: _____

Date: _____