Lotus SALON & SPA

Eyelash/Health History Form

Name (print first and last):

_____

D.O.B:

_____

Have you had lash extensions before?

_____

If yes, when?_____ How often?

_____

Any adverse reactions?

_____

Have you had lash extensions removed?

_____

If yes, when? (must wait 48 hr)_____

Any adverse reactions?

_____

Have you used under eye gel pads?

_____

If yes, any adverse reactions?

_____

Have you had permanent makeup applied?

_____

If yes, when?

_____

(Please provide evidence of clearance from service provider)

Do you wear contacts?

_____

If yes, please DO NOT wear contacts the day of your lash appointment

Do you rub your eyes or pull on lashes?

_____

If yes, indicate which:

_____

Do you go tanning? (UV or Spray Tan):

_____

If yes, you must wait 24hr before and after lash application

Are you pregnant?

_____

If yes, have you consulted your doctor?

_____

Which side do you sleep on?

_____

Do you exercise?

_____

If yes, note, excessive sweat may decrease lash retention

Are you on a special diet?

_____

If yes, note, diet may affect hair growth/lash retention

Do you have an allergy to any of the following?

- Acrylates\Cyanoacrylates
- Nail adhesives
- Tape
- Latex
- Long lasting/waterproof makeups (mascara, liquid liner, etc.)
- Cosmetic/skincare products
- None
- Other_____
  _____

Have you recently had any of the following?

- Eye Surgery, wounds, infections
- Exfoliation, skin tightening or resurfacing treatments (microdermabrasion, chemical peel, etc.)
- Use of Retin-A, Accutane or similar
- History of eye disease, or condition
- Other_____
  _____

How would you describe your hair growth?

_____

Please note, medications used to treat the following conditions may cause natural hair/lash loss. Please indicate if you have any of the below conditions and are using medications to treat:

Acne	Glaucoma	Parkinson's	Inflam
Thyroid Disease	Clotting Disorder	Weight Loss	Allergi
Birth Control	Gout	Dry Eye	Fungus
Cancer	High Blood Pressure	Ulcers	Depress
Autoimmune Disease	High Cholseterol	Seizure Disorder	Hormon Imbalan

List all current medications, herbal supplements, and vitamins:

_____

_____

_____

Please circle all conditions that apply:

Alopecia	Migraines	Dry Eye
Asthma	Ocular Rosacea	Eye Sties or Sores
Back Pain	Overactive Bladder	Heavy Eyelids
Belpharitis	Rosacea	Leamy Eye
Bronchitis	Seizure Disorder	Hormonal Disorder
Claustrophobia	Sensitive Eyes	Auto Immune Disease
Cold Sores	Light Sensitvity	Redness/Rash/Hives
Conjunctivitis	Sinus Problems	Diabetes
Stress	Trichtillomania	Stroke
Thyroid Disease	None	Other

If other, please explain:

_____

Please return this form, along with consent form AT LEAST 24 HOURS prior to your lash extension appointment. If you have/had any of the diseases/conditions/procedures listed in this history form

please ensure that you have: surpassed the healing time frame, do not have any open wounds/sores, completed antibiotics/medications/serums prior to your appointment.