◆ Client History ◆

Name_____Birth date_____

Contact Phone_____

Emergency Contact_____Phone_____

Referred by:_____

Date of mastectomy:_____ Unilateral: R L Bilateral___ Date of last surgery:_____

Date of breast reconstruction:_____ Nipple reconstruction:_____

Type of reconstruction: Implant__ Tram__ Diep__ Other_____

List any difficulties in healing:_____

Circle if the breast skin has been exposed to: Radiation Date:_____ Other_____Date:_____

ALLERGIES: Check if you have ever had an allergic reaction to any of the following and describe what happened below:

_____ Lanolm _____ Latex rubber ____ Novocaint
_____ Bacitracin Ointment _____ Novocaint _____Lidocaine
_____ PABA _____ Metals _____Neomycin or polymyxin B ointment
_____ Foods_____
_____ Other Allergies_____
Reactions: _____

SKIN: Check all of the following that apply:

_____Any other tattoos, location_____
Age of tattoo: _____ any problems: _____
_____Any keloid scars? _____ Location: _____
_____ Bruise or bleed easily? _____
_____ Healing problems?_____
_____ Other active dermatological disorders: _____

GENERAL MEDICAL: Check all of the following that apply:

_____High blood pressure? _____
_____Diabetes? _____
_____Currently on blood thinners or anticoagulants such us Aspirin, Ibuprofen, Coumadin, Alcohol Hemophilia_____
_____Other clotting disorders? _____
_____Mitral valve prolapse or valve implants? _____
_____Heart Palpitations? _____
_____Taken Accltane within the last 6 months? _____
_____Ever had Hepatitis -- When? _____
_____Seizures – describe: _____
_____ Autoimmune disorders: _____

List any medication or condition that may impact your tattoo:

_____

_____

Physician's name: _____Phone:_____

This history has been reviewed by the technician and my questions have been satisfactorily answered. I have also received and reviewed a copy of the aftercare sheet. I understand them and agree to follow agree to follow them.

Client Signature: _____Date_____