Name: _____

Date: _____

by Jo Mousselli™
XTREME LASHES®

Client History Form

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home # _____ Business #: _____ Cell #: _____

Email: _____ Fax #: _____

How do you prefer to be contacted? (Circle one) Home Cell Business Email

When do you prefer to be contacted? (Circle one) Morning Daytime Evening

Birthday: _____ Anniversary: _____

Sex: (Circle one) Female Male Age: _____

Occupation: _____

Emergency Contact Name: _____

Emergency Contact Phone #: _____ Relationship to you: _____

How did you hear about us? _____

Question	Y	N	How Often?	Adverse Reactions?
1. Have you received eyelash extensions before?				
2. Have you had eyelash extensions removed?				
3. Have you used under-eye gel patches before?				
4. Have you had permanent cosmetics applied to your eyes?				
5. Do you wear glasses?				
6. Do you wear contacts?				
7. Are you wearing contacts today?				
8. Do you have a tendency to rub your eyes and/or pull on your eyelashes?				
9. Do you go tanning (in salon or outside) or get spray tans?				
10. Are you pregnant?				

11. Which side do you sleep on:
    - ❑ Right
    - ❑ Left
    - ❑ Back

*Please note that you may experience more lash loss on the side on which you sleep.

Client History Form

12. Do you exercise?
    - ❑ Yes* (If yes, fill out the chart below.)
    - ❑ No

*Please be sure to follow After Care Instructions regarding protecting your Xtreme Lashes® Eyelash Extensions while exercising.

Type of Activity	Frequency # times/ week	Indoors or Outdoors?
1.		
2.		
3.		
4.		

13. What brands are you currently using around your eyes? Please indicate the brand of product you use for each and how often you wear it.

Product Brand	Frequency of Use Daily: # times per day	Frequency of Use Weekly: # times/week	Frequency of Use Monthly: # times/month
Cleanser:			
Toner:			
Eye Treatment:			
Day Moisturizer:			
Night Moisturizer:			
Eye Cream:			
Eye Serum:			
Mask:			
Sunscreen:			
Mascara Brand:			
Eyeliner Brand:			
Eye Shadow Brand:			
Eyelash Enhancer/ Conditioner:			

**Please note: Discontinue use of cosmetics until 48 hours after lash application. The use of heavy oils, creams and Vaseline that may come into contact with your Xtreme Lashes® Eyelash Extensions should be discontinued for the duration of your lashes.

Client History Form

MEDICAL HISTORY:

Question	Y	N	Type(s)	Date of most recent / How often?	Adverse Reactions? Describe symptoms.
14. Do you have an acrylate or cyanocarylate allergy (Ex: Dermabond)?					
15. Any allergies to nail adhesives?					
16. Any allergies, including those that affect your eyes, skin, or respiratory system?					
17. Any allergies to medications?					
18. Any allergies to cosmetic or skin care products or ingredients?					
19. Any allergies to topical creams, adhesive tape, or other topical products?					
20. Recent eye surgery, scars, or infections?					
21. Have you had any exfoliation, skin tightening or skin resurfacing facial treatments, including but not limited to acne treatments, chemical peels, microdermabrasion, Thermage or Fraxel?					
22. Are you currently or have you previously used Retin A or Accutane?					
23. Do you have a history of any type of eye disease, condition, or injury that affected your hair/ lash growth or loss?					
24. Have you noticed that your hair growth cycle is slower or faster than others?					

Client History Form

25. Please list all current medications:

26. Please note that many medications have a side effect of hair loss. These include but are not limited to medications used for the following. Please mark all that apply:

- ❑ Acne
- ❑ Anticoagulants
- ❑ Birth Control
- ❑ Convulsions/ Epilepsy
- ❑ Depression
- ❑ Diet/ Weight Loss
- ❑ Fungus
- ❑ Glaucoma
- ❑ Gout
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Hormonal
- ❑ Inflammation
- ❑ Parkinson's disease
- ❑ Thyroid disease
- ❑ Ulcers
- ❑ Cancer

27. Please mark all conditions that apply:

- ❑ Alopecia
- ❑ Asthma
- ❑ Autoimmune disease
- ❑ Back pain
- ❑ Bell's Palsy
- ❑ Blepharitis
- ❑ Bronchitis
- ❑ Claustrophobia
- ❑ Cold Sore
- ❑ Conjunctivitis
- ❑ Diabetes
- ❑ Diabetic Retinopathy
- ❑ Dry Eye Syndrome
- ❑ Heavy eyelid
- ❑ Hormonal disorders or changes
- ❑ Leamy eye
- ❑ Migraines
- ❑ Ocular rosacea
- ❑ Rosacea
- ❑ Sensitive eyes
- ❑ Sensitivity to light
- ❑ Sinus problems
- ❑ Stress
- ❑ Stroke
- ❑ Tendency of redness, rashes, or hives
- ❑ Thyroid disease
- ❑ Trichotillomania
- ❑ Other: _____

Date	Additional Comments