RefectoCil®

EYELASH TINTING & PERMING CONSULTATION FORM

Name: _____ Date: _____/ _____/ _____

Address: _____

Phone: (___) _____ Email: _____

Tinting/Perming Technician: _____

How did you hear about us? ___ Magazine ___ Website ___ Reference ___ Other: _____

Have you ever had your lashes and/or brows tinted or permed? ___ Yes ___ No

If yes, when? _____

Were you happy with the results? _____

Have you ever had an adverse reaction to hair colour or previous tinting/perming products?

Please explain: _____

What brings you in today?

___ Consultation ___ Eyelash Tint ___ Brow Tint ___ Lash & brow Tint ___ Eyelash Perming

Do you wear contacts? ___ Yes ___ No

Have you undergone any recent eye surgery? ___ Yes ___ No If yes, when? _____

Do you have any eye condition or injury? ___ Yes ___ No

Please list any medication you are using:

_____

Are you allergic to latex or rubber? ___ Yes ___ No

Do you have any intolerance to chemicals, a hypersensitivity to odours? ___ Yes ___ No

If yes, please specify: _____

Please check off beside all that might apply to you:

Stress		Seasonal Allergies		Lumps/Cysts	
Lasik Eye Surgery		Alopecia		Cold Sores around Eyes	
Permanent Eye Make-up		Hormonal Imbalance		Psoriasis	
Diabetes		Hypersensitive Eyes		Pink Eye	
Blepharoplasty		Thyroid Diseases		Sty of the Eye	

Signature: _____ Date: _____/ _____/ _____