

## Consent to Eyelash Extension Application:

### Health History:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_

Cell # \_\_\_\_\_ Alternate: \_\_\_\_\_

Email: \_\_\_\_\_

How did you hear about us?-

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Please list any allergies you have:-

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Are you allergic to Acrylate/ Cynoacrylate (bonding agents)?      Y      N

Have you ever had an allergic reaction to sensitivity to adhesive tape, Band-aids, topical creams, nail adhesive or any other topical products?      Y      N

Are you allergic to rubber or latex?      Y      N

Do you have any eye diseases, conditions or injury that has affected your hair or eyelash growth such as thyroid problems, alopecia or trichotillomania?      Y      N

Do you now use or have you used a lash growing product such as latisse, revitalash, LiLash, etc?      Y      N

Please list all medications and herbal supplements: \_\_\_\_\_

Do you have any missing lashes or gaps between lashes?      Y      N

How would you describe your lashes?      Thin      Short      Weak      Thick      Long      Wispy      Curly      Sparse      Full

How would you like your lashes to look? \_\_\_\_\_

Have you had eyelash extensions in the past?      Y      N

Can you explain why you discontinued to wear past extensions?

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