MAKE-UP CONSULTATION SHEET

Portfolio reference:

Clients name:				Date:
Address:			Phone number: Mobile: Email address:	
Dr's name: Address: Phone number:				
Age range:	Under 16 ☐	16 - 30 ☐	30 - 50 ☐	50+ ☐
Occupation:				
Hobbies:				

This information is to be checked through during consultation by the make-up artist

Relevant medical history and lifestyle notes			
Allergies	Yes/No	Boils	Yes/No
Viral infections (E.g. Herpes simplex,herpes zoster,warts)	Yes/No	Parasitic infections (E.g. Scabies,pediculosis)	Yes/No
Bacterial infections (e.g. impetigo)	Yes/No	Eye infections (E.g. Conjunctivitis,styes,blepharitis)	Yes/No
Fungal infections (E.g. tinea)	Yes/No	Watery eyes	Yes/No
Severe skin conditions	Yes/No	Cuts or abrasions	Yes/No
Severe acne	Yes/No	Swelling/undiagnosed lumps	Yes/No
Irritation	Yes/No	Recent scar tissue	Yes/No
Eczema/Psoriasis	Yes/No	Bruising	Yes/No
Hyperkeratosis	Yes/No	Hypersensitive skin	Yes/No
Botox/Dermal fillers	Yes/No	Respiratory conditions (asthma)	Yes/No
Claustrophobia	Yes/No	Sunburn	Yes/No
Recent surgery	Yes/No	Chemotherapy	Yes/No
Trichotillomania	Yes/No	Glaucoma	Yes/No
Dry eye syndrome	Yes/No	Thyroid imbalances	Yes/No
Do you take regular medication? If **yes** please state which medication:			Yes/No
Do you wear contact lenses/glasses? If **yes**, how often?			Yes/No
Current skin care routine:			
Current make-up products used:			
Reason for service:			

Patch test date (if required):
Product(s) tested:
Results:

Skin analysis:						
Skin type	Normal	☐	Dry	☐	Oily	☐
	Combination	☐				
Skin condition	Sensitive	☐	Dehydrated	☐	Mature	☐
	Broken capillaries	☐	Papules	☐	Open pores	☐
	Dark circles	☐	Pigmentation	☐	Scarring	☐
	Erythema	☐				

Client signature for permission to treat:	
Therapist/Make-up artist signature:	**Date:**

Date:

Treatment/Service	Tools/products used	Advice given/Comments

Date:

Treatment/Service	Tools/products used	Advice given/Comments

Date:

Treatment/Service	Tools/products used	Advice given/Comments

Date:

Treatment/Service	Tools/products used	Advice given/Comments