EYELASH EXTENSIONS CONSULTATION FORM

Name: _____ Date: _____/ _____/ _____

Address: _____

Phone: (___) _____ Email: _____

MICHA Lash Technician: _____

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

Have you ever had eyelash extensions applied? ___ Yes ___ No If yes, when? _____

Did you have a good experience? _____

Do you perm or tint you lashes? ___ Yes ___ No

What brings you in today?

___ Consultation ___ Refill ___ Full/Half Set ___ Special Event ___ Removal of Extensions

What look do you want to achieve today? ___ Natural ___ Cat Eye ___ Glamour ___ N/A

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 hyper sensitivity to odours? ___ Yes ___ No

If yes, please specify: _____

Please check off beside all that might apply to you:

Iron Deficiency		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	
Stress		Asthma		Use of Retin A or Accutane	
Allergy to adhesives/glues		Anticoagulants		Chemotherapy	

Signature: _____ Date: _____/ _____/ _____