

11. Do you exercise?

Yes (If yes, fill out the chart below.)

No

Type of Activity	Frequency # Times / Week	Indoors or Outdoors?	Stylist Notes
1.			
2.			
3.			
4.			

12. Are you on a special diet?

Yes*

No

Please be advised that healthy natural eyelashes and hair growth require a diet rich in amino acids and protein. In addition, low-carb, low-protein and quick-results diets may affect a body's chemical balance, which can lead to loss of or damage to hair/natural eyelashes.

If client is on a special diet recommend Amplifeye® Lash & Brow Fortifier and Amplifeye Lash & Brow Supplement.

13. What brands and products are you currently using around your eyes?

Product Name & Brand	Frequency of Use (Per day / Week / Month)	Stylist Notes
Facial Cleanser:		
Facial Mask:		
Facial Toner:		
Facial Primer:		
Day Moisturizer:		
Night Moisturizer:		
Facial Sunscreen:		
Eye Treatment:		
Eye Primer:		
Eye Cream:		
Eye Serum:		
Eye Makeup Remover:		
Eyeliners:		
Eye Shadow:		
Mascara:		
Eyelash Fortifier/ Conditioner:		
Brow Products		
Hair, Skin and Nail Supplements		

MEDICAL HISTORY:

Questions	Y	N	Type(s)	Date & Frequency	Adverse Reactions? <i>Describe symptoms</i>	Stylist Notes
14. Do you have an allergy to any of the following? If yes, please provide additional information.						
Acrylates or cyanoacrylates? <i>(Example: Topical skin adhesives)</i>	<input type="checkbox"/>	<input type="checkbox"/>				
Nail adhesives?	<input type="checkbox"/>	<input type="checkbox"/>				
Tape (bandages)?	<input type="checkbox"/>	<input type="checkbox"/>				
Long-lasting or waterproof cosmetics?	<input type="checkbox"/>	<input type="checkbox"/>				
Cosmetic, skin care products, topical creams or other topical products or ingredients?	<input type="checkbox"/>	<input type="checkbox"/>				
Any allergies not including those listed above?	<input type="checkbox"/>	<input type="checkbox"/>				
15. Have you had or used any of the following in the last 4 weeks?						
Eye surgery, wounds or infections?	<input type="checkbox"/>	<input type="checkbox"/>				
Exfoliating, skin-tightening or skin-resurfacing facial treatments? (Examples: Acne treatments, chemical peels, microdermabrasion, laser)	<input type="checkbox"/>	<input type="checkbox"/>				
Retin-A, Accutane or similar product?	<input type="checkbox"/>	<input type="checkbox"/>				
History of eye disease, condition, injury or surgery that affected your hair/natural eyelash growth or loss?	<input type="checkbox"/>	<input type="checkbox"/>				

16. How would you describe your hair growth cycle as compared to others? Slow Fast Unsure

17. Please note that **medications** used to treat the following conditions may cause hair/natural eyelash loss. If you are on medications to treat any of the following, please mark them below:

- | | |
|---|--|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Allergies (when treated with non-steroidal anti-inflammatory drugs (NSAIDS)) | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Anticoagulants | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Autoimmune diseases | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Birth control* | <input type="checkbox"/> Hormone imbalance, hormone therapy* |
| <input type="checkbox"/> Convulsions/ epilepsy | <input type="checkbox"/> Inflammation (when treated with NSAIDS) |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Parkinson's disease |
| <input type="checkbox"/> Diet/ weight loss | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Dry eye syndrome | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Fungus | <input type="checkbox"/> Cancer |

*Although these are not medical conditions, birth control and hormone therapy may result in the thinning or loss of natural eyelashes.

18. List all current medications, herbal supplements and vitamins:

19. Please mark all conditions that apply:

- | | |
|--|---|
| <input type="checkbox"/> Alopecia | <input type="checkbox"/> Hormonal disorders or changes |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Leamy eye or excessive tearing |
| <input type="checkbox"/> Autoimmune diseases (Crohn's disease, arthritis, lupus, ulcerative colitis, etc.) | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Ocular rosacea |
| <input type="checkbox"/> Bell's Palsy | <input type="checkbox"/> Overactive bladder |
| <input type="checkbox"/> Blepharitis | <input type="checkbox"/> Rosacea |
| <input type="checkbox"/> Bronchitis (chronic) | <input type="checkbox"/> Seizure disorder |
| <input type="checkbox"/> Claustrophobia | <input type="checkbox"/> Sensitive eyes |
| <input type="checkbox"/> Cold sore | <input type="checkbox"/> Sensitivity to light |
| <input type="checkbox"/> Conjunctivitis (pink eye) | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Diabetic retinopathy | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Dry eye syndrome | <input type="checkbox"/> Tendency of redness, rashes or hives |
| <input type="checkbox"/> Eye sties or sores | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Heavy eyelid | <input type="checkbox"/> Trichotillomania (hair or eyelash pulling) |
| | <input type="checkbox"/> Other: _____ |

Basic makeup application and normal lifestyle can resume after the eyelash extension application. However, the following activities should be avoided within the first 3 hours: spray or airbrush tanning, exposure to excessive steam, exposure to excessive heat, contact lenses insertion, and non Xtreme Lashes® cosmetics & skincare products

Date	Additional Comments