Lash History Form

Guest Name: _____ Date: _____

Question	Y	N	Date & Frequency	Adverse Reactions? *Describe symptoms*	Stylist Notes
1. Have you received eyelash extensions before?					
2. Have you had eyelash extensions removed?					
3. Have you used under eye gel patches before?					
4. Have you had permanent cosmetics applied to your eye area?					
5. Do you wear glasses?					
6. Do you wear contacts?					
7. Do you have a tendency to rub your eyes or pull on your eyelashes?					
8. Do you go tanning (indoor booth or outside) or spray tans?					
9. Are you pregnant? If yes, have you discussed having this service with your doctor?					

10. Which side do you sleep on*?

- ☐ Right
- ☐ Left
- ☐ Back
- ☐ Stomach

**Please note that you may experience more eyelash extension loss on the side on which you sleep.*

11. Do you exercise?

- ☐ Yes (If yes, please fill out the chart below.)
- ☐ No

**Please note that certain activities may affect the longevity of your lashes. Your stylist can provide tips to extend the longevity.*

Type of Activity	Frequency # times/week	Indoors or Outdoors	Stylist Notes
1.			
2.			
3.			

12. Are you on a special diet?

- ☐ Yes*
- ☐ No

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

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13. What brands and products are you currently using?

Product Name & Brand	Frequency of Use (per day/week/month)	Stylist Notes
Facial Skin Care:		
Facial Sunscreen:		
Eye Cream:		
Eye Shadow:		
Eye Liner:		
Mascara:		
Eye Makeup Remover:		
Eyebrow Products:		
Hair, Skin, Nail Supplements:		

Tip: Products containing oils may cause premature shedding. So will Neutogena Makeup Wipes!

14. What are your known allergies? (please include all medications and products)

15. List all current medications, herbal supplements and vitamins.

16. Have you had or used any of the following in the last 4 weeks?

Question	Y	N	Date & Frequency	Adverse Reactions? *Describe symptoms*	Stylist Notes
Eye surgery, wounds or infections?					
Exfoliation, skin-tightening or skin resurfacing facial treatments? (acne treatments, microdermabrasion, chemical peels, laser)					
Retin-A, Accutane or similar product?					
History of eye disease, condition, injury or surgery that affected natural eyelash growth or loss?					

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

18. Please mark all conditions that apply.

- ☐ Alopecia
- ☐ Asthma
- ☐ Autoimmune diseases
- ☐ Back pain
- ☐ Bell's Palsy
- ☐ Blepharitis
- ☐ Bronchitis (chronic)
- ☐ Claustrophobia
- ☐ Cold Sore
- ☐ Conjunctivitis -pink eye
- ☐ Diabetes
- ☐ Diabetic retinopathy
- ☐ Dry eye syndrome
- ☐ Eye sties or sores
- ☐ Heavy eyelid
- ☐ Hormonal disorders
- ☐ Leamy eye or excessive tearing
- ☐ Migraines
- ☐ Ocular rosacea
- ☐ Overactive bladder
- ☐ Rosacea
- ☐ Seizure disorder
- ☐ Sensitive eyes
- ☐ Sensitivity to light
- ☐ Sinus problems
- ☐ Stress
- ☐ Stroke
- ☐ Tendency of redness, rashes or hives
- ☐ Thyroid disease
- ☐ Trichotillomania (hair and eyelash pulling)

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