



**BELLA VIA**  
Skin and Body Therapies

# EYELASH EXTENSIONS INTAKE FORM

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Email Address: \_\_\_\_\_ Occupation: \_\_\_\_\_

(Your email address will be used for appointment confirmations, quarterly newsletters, and to alert you of specials and promotions.)

How were you originally referred to Bella Via? (Please circle and add note if applicable.)

Dr. Colville          Dr. Zavell          Website          Friend: \_\_\_\_\_

Other: \_\_\_\_\_

## AREA SPECIFICS

Is this the first time that you have had eyelash extensions applied?          YES          NO

If no, where did you have them applied? \_\_\_\_\_

Please indicate if you have worn any of the following types of eyelashes within the last 60 days:

Individual           Strip           Flare           Other \_\_\_\_\_

Do you do any of the following to your eyelashes? (Please check all that apply.)     curl     perm     tint

Are you having eyelash extensions applied for:     daily wear           a special occasion

Do you wear contacts?          YES    NO

Do you habitually rub, pull, or pick your eyelashes for any reason?          YES          NO

Do you have, or are you being treated for, any eye illness or injury?          YES          NO

What side do you predominately sleep on?          RIGHT          LEFT

Please list any eye drops or eye medications that you are currently using: \_\_\_\_\_

Do you have any allergies to adhesives, tape, paper tape or synthetics?          YES          NO

If so, please list your reaction(s): \_\_\_\_\_

Are you able to keep your eyes closed and lie still for up 2 hours or longer?    YES          NO

Please check any of the following that apply to you:

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Lasik Eye Surgery   | <input type="checkbox"/> Dry Eye                             | <input type="checkbox"/> Permanent Cosmetics     | <input type="checkbox"/> Blepharoplasty     |
| <input type="checkbox"/> Microdermabrasion   | <input type="checkbox"/> Seasonal Allergies                  | <input type="checkbox"/> Alopecia                | <input type="checkbox"/> Thyroid Diseases   |
| <input type="checkbox"/> Glycerin Allergies  | <input type="checkbox"/> Iron Deficiency                     | <input type="checkbox"/> Ringworm                | <input type="checkbox"/> Major Surgery      |
| <input type="checkbox"/> Eating Disorders  | <input type="checkbox"/> Oral Contraceptives                 | <input type="checkbox"/> Anticoagulants          | <input type="checkbox"/> Retinoids          |
| <input type="checkbox"/> Accutane  | <input type="checkbox"/> Beta-adrenergic Blockers            | <input type="checkbox"/> Chemotherapeutic Agents | <input type="checkbox"/> Hormonal Imbalance |
| <input type="checkbox"/> Recent High Fever   | <input type="checkbox"/> Severe Illness                      | <input type="checkbox"/> Flu Symptoms            | <input type="checkbox"/> Extreme Stress     |
| <input type="checkbox"/> Drugs that Cause Hair Loss  | <input type="checkbox"/> Childbirth within the last 120 days |  |   |
| <input type="checkbox"/> Exposure to Chemicals in Swimming Pools, Bleach, Hair Dye, or Perms |  |  |   |
| <input type="checkbox"/> Hypersensitivity to Cyanoacrylate or Formaldehyde                   |  |  |   |