

**Medical History Form**

FOR OFFICE USE ONLY  
Color Lot # \_\_\_\_\_  
Color Lot # \_\_\_\_\_  
Color Lot # \_\_\_\_\_

Today's Date: \_\_\_/\_\_\_/\_\_\_

Name: \_\_\_\_\_

Email Address \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_

Home Address \_\_\_\_\_  
Street City State Zip

Work Address \_\_\_\_\_  
Street City State Zip

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Are you now or have you been under the care of a physician within the last two years? \_\_\_\_\_ *If yes, please provide Physician's Name, address and phone number.* \_\_\_\_\_

Person to contact in an emergency: \_\_\_\_\_  
Name  
\_\_\_\_\_  
Address & Phone No.

List all medications you are currently taking, including Retin A, Glycolic Acid and Acutane:

\_\_\_\_\_

List any drug, makeup shin or food allergies (i.e., soaps or cleansing creams): \_\_\_\_\_

Have you recently undergone a skin peel? \_\_\_\_\_

What products do you use for skin care? \_\_\_\_\_

**Do you have or have you had any of the following conditions (answer Yes or No):**

- |   |                                       |
|---|---------------------------------------|
| _____ Abnormal Heart Condition                                    | _____ "Dry Eye"                       |
| _____ Cold Sores  | _____ Corneal Abrasions               |
| _____ Herpes Simplex  | _____ Eye Surgery or Injury           |
| _____ Hemophilia  | _____ Blepharoplasty (eyelid surgery) |
| _____ High or Low Blood Pressure                                  | _____ Visual Disturbances             |
| _____ Prolonged Bleeding  | _____ Cancer                          |
| _____ Circulatory Problems  | _____ Tumors/Growths/Cysts            |
| _____ Epilepsy  | _____ Chemotherapy/Radiation          |
| _____ Diabetes  | _____ Are you pregnant?               |
| _____ Fainting Spells/Dizziness                                   | _____ Hepatitis                       |
| _____ Cataracts   | _____ Do you wear contact lenses?     |
| _____ Glaucoma  | _____ Do you use tobacco products?    |
| _____ Are you using any eye drops or other ocular medications?    |                                       |
| _____ Have you ever experienced hyperpigmentation from an injury? |                                       |
| _____ Are you currently taking aspirin or ibuprofen?              |                                       |

When was your last eye exam? \_\_\_/\_\_\_/\_\_\_

Examining Physician: \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date