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, Glyclolic 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
______ Cold Sores
______ Herpes Simplex
______ Hemophilia
______ High or Low Blood Pressure
______ Prolonged Bleeding
______ Circulatory Problems
______ Epilepsy
______ Diabetes
______ Fainting Spells/Dizziness
______ Cataracts
______ Glaucoma
______ "Dry Eye"
______ Corneal Abrasions
______ Eye Surgery or Injury
______ Blepharoplasty (eyelid surgery)
______ Visual Disturbances
______ Cancer
______ Tumors/Growths/Cysts
______ Chemotherapy/Radiation
______ Are you pregnant?
______ Hepatitus
______ Do you wear contact lenses?
______ 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