Medical History Form

Name: _____ Today's Date: ____/____/____ Birth date: _____/_____/_____

Home Address:

_____

No. & Street City State Zip code

Home Phone: (_____) _____ Cell Phone: (_____) _____

Email: _____

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 and Accutane: _____

List any drugs, makeup, skin 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 whiten your teeth?

_____

Do you use any blood thinning medication?

_____

Have you had alcohol within the last 24hours?

_____

Do you use a lip plumper?

_____

Are you allergic to Lidocaine or epinephrine?

_____

Are you using a Lash growth product?

_____

Medical History Form Continued (answers 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 _____

Tumors/Growths/Cysts _____

Prolonged Bleeding _____

Chemotherapy/Radiation _____

Circulatory Problems _____

Visual Disturbances _____

Date of last eye exam_____

Examining Physician:

_____

_____

_____

Signature _____

Date_____