Medical HistoryForm

______/______/______
Today's Date

_______-_______-_______ _______-_______-_______ _______-_______-_______
DOB Home # Cell #

____
Occupation:

Are you now or have you been under the care of a physician within the las two years? **Yes / No**
If **Yes**, please provide physician's name, address and phone number:

Name: __________________________________ Phone: ____________________________

Address: ____

Person to contact in an emergency:

Name: _____________________________________ Phone:________________________

Address: ____

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

____
List all drugs, makeup skin or food allergies (i.e., soaps or cleansing creams):

Have you recently undergone a skin peel? **Yes / No**
What products do you use for skin care? ____
Do you have or have you had any of the following conditions **Yes / No**

___Abnormal Heart Conditions
___Hemophilia
___Circulatory Problem
___Fainting Spells / Dizziness
___"Dry Eye"
___Blepharoplasty (eyelid surgery)
___Tumors / Growth / Cysts
___Hepatitis
___Cold Sores
___High/Low Blood Pressure
___Epilepsy
___Cataracts
___Corneal Abrasions
___Visual Disturbances
___Chemotherapy/Radiation
___Do You Wear Contacts
___Herpes Simplex
___Prolong Bleeding
___Diabetes
___Glaucoma
___Eye Surgery or Injury
___Cancer
___Are You Pregnant
___Do You Use Tobacco
___Are you using eye drops or other ocular medications? **You / No**
___Have you ever experienced hyper-pigmentation from any injury? **Yes / No**
___Are you currently taking aspirin or ibuprofen? **Yes / No**

_______-_______-_______ ____
When was your last eye exam? Examining Physician:

____ _______-_______-_______
Signature Date