

**MEDICAL HISTORY  
CONFIDENTIAL**

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

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. \_\_\_\_\_

**HAVE YOU EVER HAD ANY OF THE FOLLOWING PROCEDURES, DISEASES,  
OR MEDICAL PROBLEMS?**

Diabetes	Y/N	Plastic Surgery	Y/N	Cancer	Y/N	Chemo/Radiation	Y/N
Tuberculosis (TB)	Y/N	Chemical Peel	Y/N	Heart Murmur	Y/N	Rheumatic Fever	Y/N
Glaucoma	Y/N	Lazer Resurfacing	Y/N	Heart Attack	Y/N	Stroke	Y/N
Retina Transplant	Y/N	Dermabrasion	Y/N	Heart Surgery	Y/N	Artificial Valves	Y/N
Cataracts	Y/N	Cheek/Chin Implants	Y/N	Pacemaker	Y/N	Mitral Valve Prolapse	Y/N
RK/PRK/Lasik	Y/N	Breast Lumps	Y/N	High Blood		Blood Transfusion	Y/N
Eye Infections	Y/N	Collagen	Y/N	Pressure	Y/N	Artificial Joints	Y/N
Contact Lenses	Y/N	Retin A	Y/N	Jaundice/		Hemophilia	Y/N
Any Eye Problems	Y/N	Glycolic Acid	Y/N	Anemia	Y/N	Asthma	Y/N
Sinus Problems	Y/N	Eczema	Y/N	Lupus	Y/N	Fever Blisters	Y/N
Blurred Vision	Y/N	Drug Rehab	Y/N	Respiratory		Epilepsy/Seizures	Y/N
Allergies-seasonal	Y/N	Mental Disease	Y/N	Problems	Y/N	Kidney Problems	Y/N
Tearry Eyes	Y/N	Anxiety Attacks	Y/N	Arthritis	Y/N	HIV/AIDS	Y/N
Headaches/Migraine	Y/N	Hepatitis	Y/N	Back Pain	Y/N	Pregnant (Now)	Y/N
Keloids	Y/N	Narcolepsy	Y/N	Skin sensitivities		Skin diseases	Y/N
Alopecia	Y/N	Sensitivities to soaps	Y/N	to disinfectants	Y/N		
Shingles	Y/N	Skin lesions	Y/N				
Fainting	Y/N						
Intraocular lens							
Transplant	Y/N						

List any other diseases that you might have that are not listed above: \_\_\_\_\_

**ARE YOU ALLERGIC TO ANY OF THE FOLLOWING DRUGS?**

Benadryl	Y/N	Neosporin	Y/N	Bacitracin	Y/N	Petroleum	Y/N
Sulfa	Y/N	Vaseline	Y/N	Aloe Vera	Y/N	PABA	Y/N
Cortisone	Y/N	Aspirin	Y/N	Tylenol	Y/N	Penicillin	Y/N
Codeine	Y/N	Erythromycin	Y/N	Xylocaine	Y/N	Lidocaine	Y/N
Benzocaine	Y/N	Latex/Vinyl	Y/N			Metals	Y/N

List any other drug/antibiotics that you are allergic to: \_\_\_\_\_

**CIRCLE MEDICATIONS YOU ARE NOW TAKING/USING**

Blood Pressure Pills	Y/N	Diabetic Pills	Y/N	Insulin	Y/N
Blood Thinning Pills	Y/N	Aspirin	Y/N	Vitamin E	Y/N
Antibiotics	Y/N	Sleeping Pills	Y/N	Tranquilizers	Y/N
Headache Pills	Y/N	Steroids	Y/N	Hormones	Y/N
Arthritis Meds	Y/N	Herbs	Y/N	Retin A	Y/N
Acutane	Y/N	Glycolic Acid	Y/N		
Anticoagulants	Y/N				

List any other meds you are taking: \_\_\_\_\_

MY SIGNATURE BELOW CONSTITUTES MY ACKNOWLEDGE THAT ALL OF THE ABOVE INFORMATION CONTRIBUTED BY ME IS ACCURATE. I ALSO UNDERSTAND THAT IF I AM UNDER DOCTORS CARE FOR CERTAIN MEDICAL CONDITIONS, I WILL NEED THAT DOCTOR'S RELEASE TO HAVE THIS PROCEDURE PERFORMED.

CLIENT SIGNATURE: \_\_\_\_\_