Beautiful SOLUTIONS

MEDICAL HISTORY FORM

Today's Date: ___/___/___ Birth Date: ___/___/___

Name: ____

Home Address: ____

City, State & Zip:____

Phone No: ____

Work Address: ____

Email Address: ____

Would You Like To Receive Text Messages for Events and Confirmations? _________

Employer: ______________________________ Occupation: ______________________________

Are you now or have you been under the care of a physician within the last two years? _________

Person to contact in an emergency: ____
Name, Address & Phone Number

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

List any drug, makeup, skin or food allergies (i.e. soaps or cleansing creams): ________________

Do you have or have you had any of the following conditions (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"
_____ Are you using any eye drops or other ocular medications?
_____ Do you get pigment or brown spots from an injury, insect bite or cut?
_____ Are you currently taking aspirin or ibuprofen?
_____ Have you recently undergone a skin peel?
_____ Have you consumed any alcoholic beverage (s) in the past 24 hours?
_____ Are you currently on Antibiotics or taken in last 5 days?
_____ Corneal Abrasions
_____ Eye Surgery or Injury
_____ Blepharoplasty (eyelid surgery)
_____ Visual Disturbances
_____ Cancer
_____ Tumors/Growths/Cysts
_____ Chemotherapy/Radiation
_____ Are you pregnant?
_____ Hepatitis
_____ HIV/AIDS
_____ Do you wear contact lenses?
_____ Do you use tobacco products?

What products do you use for skin care? ______________________________

What services are you interested in today?

_____ Laser Hair Removal
_____ Botox
_____ Spider Vein Removal
_____ Microdermabrasion
_____ Facials
_____ Skin Tightening
_____ Vibraderm
_____ Dermal Planning
_____ Eyelash Perming/Tinting
_____ IPL/Photofacial
_____ Juvederm/Radiesse
_____ Chemical Peel
_____ Body Wraps

Source of Referral: ____

______________________ ______________________
Signature Date