

Patient Medical History

Patient's Name: _____ Date of Birth: _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Best Phone Number to Reach You: _____ Alternative Phone Number: _____

Employer: _____ Occupation: _____ Work Phone: _____

Person to contact in an emergency: _____
(Name, Address, and Phone #)

How did you hear about us? _____

Reason for consultation: _____

Are you currently under a physician's care? _____ Specify: _____

HAVE YOU EVER BEEN DIAGNOSED WITH:									
	Yes	No		Yes	No		Yes	No	
Diabetes:	()	()	Heart Murmur:	()	()	Phlebitis:	()	()	
Keloids:	()	()	High Blood Pressure:	()	()	Allergies:	()	()	
Bleeding Disorder:	()	()	Thyroid Disease:	()	()	Hepatitis:	()	()	
Mitral Valve Prolapse:	()	()							

DO YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING CONDITIONS:											
Yes	No		Yes	No		Yes	No		Yes	No	
()	()	Abnormal Heart Condition	()	()	Prolonged Bleeding	()	()	Cold Sores			
()	()	Diabetes	()	()	Corneal Abrasions	()	()	Cancer			
()	()	High or Low Blood Pressure	()	()	Eye Surgery or Injury	()	()	Hemophilia			
()	()	Circulatory Problems	()	()	Blepharoplasty (eyelid Surgery)	()	()	"Dry Eye"			
()	()	Fainting Spells/Dizziness	()	()	Visual Disturbances	()	()	Epilepsy			
()	()	Herpes Simplex	()	()	Tumors/Growths/Cysts	()	()	Cataracts			
()	()	Chemotherapy/Radiation	()	()	Are you pregnant?	()	()	Hepatitis			
()	()	Do you use tobacco products?	()	()	Do you wear contact lenses?	()	()	Glaucoma			
()	()	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?									

List all medications you are currently taking (including Retin A, Glycolic Acid, and Accutane):

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

Does your medication prohibit exposure to sun or light? _____

Have you been on Accutane in the last 9 months _____ Laser resurfacing in the last year? _____

Are you pregnant? _____ If so, how long? _____

Have you ever been tested for HIV _____ Results? _____

Are you prone to herpes breakouts or cold sores? _____

What is your natural hair color? _____ currently, your hair is (natural / colored)

Have you recently undergone a skin peel or microdermabrasion? _____

Is your present skin condition normal or abnormal? _____ Oily or Dry? _____

When did you last tan your skin? _____ Sun, tanning booth, or creams? _____

When was your last eye exam: _____ / _____ / _____ – Examining Physician: _____

Going back three generations, what is your ethnic background? _____

Fitzpatrick Skin Test: Please circle one of the following that describes your skin type:

A. Type I – Always burns, never tans. Red or light blonde hair, light eyes. (White)

B. Type II – Sometimes tans, mostly burns. (White)

C. Type III – Sometimes burns, mostly tans. Also known as "Olive" complexion. (White/Asian)

D. Type IV – Rarely burns, almost always tans. Also known as "Olive" complexion. (Moderate Brown)

E. Type V – Moderately pigmented. (Indian, Hispanic, etc.). (Dark Brown)

F. Type VI – African American, black skin color. (Black)

Patient's Signature: _____ **Date:** _____