Infinite Beauty

Wendy Wheeler-Ponczek 1360 Eisenhower Blvd., Suite 306, Johnstown, PA 15904 814.341.7477

Medical History Form

Today's Date: _____/_____/_____ Birth Date: _____/_____/_____

Name: _____

Home Address

_____

No. & Street City State Zip

Work Address

_____

No. & Street City State Zip

Home Phone: (_____)_____ Work Phone: (_____)_____

Employer: _____ 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 Acid and Accutane:

_____

List any drug, make-up, 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? _____

MORE INFORMATION REQUIRED ON OTHER SIDE

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Do you have or ever have had any of the following conditions (answer Yes or No):

_____ Abnormal Heart Condition
_____ Cold Sores
_____ Herpes Simplex
_____ Hemophilia
_____ High or Low Blood Pressure
_____ Cataracts
_____ Glaucoma
_____ Corneal Abrasions
_____ Eye Surgery or Injury
_____ Blepharoplasty (eyelid surgery)
_____ Visual Disturbances
_____ Cancer
_____ Prolonged Bleeding
_____ Circulatory Problems
_____ Epilepsy
_____ Diabetes
_____ Fainting Spells/Dizziness
_____ Tumors/Growths/Cysts
_____ Chemotherapy/Radiation
_____ Are you pregnant?
_____ Hepatitis
_____ Do you wear contact lenses?
_____ Do you use tobacco products?
_____ Dry Eye

_____ Are you using any eye drops or other ocular medication?

_____ Have you ever experienced hyperpigmentation for an injury?

_____ Are you currently taking aspirin or ibuprofen?

_____ Are you difficult to numb at the dentist?

When was your last eye exam? _____/_____/_____

Examining Physician: _____

_____ _____
Signature Date