
*3900 Niles Rd, Saint Joseph MI 49085 (269) 429-7368*

# Confidential Medical History

**Today's Date**: ____/____/____ **Birth Date**: ____/____/____ **Gender (F/M)**

**Name**: _____

**Mailing Address**: _____
*No. & Street City State Zip*

**Home Phone:** _____ **Work:** _____ **Cell**: _____

**E-mail address:** _____
*You will be added to the Bellissma Email Subscriber list and you will receive newsletters, specials, and event invitations. Each email includes a button to Unsubscribe so you will be able to remove yourself from the list permanently if you wish.*

**What is your preferred method for us to contact you?** _____

**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* _____
_____

Primary contact in an emergency: _____
Secondary contact: _____
*Name Address Phone Number*

List all medications you are currently taking, including R etin A, Glycolic Acid and Acutane: _____
_____

Are you using any eye drops or other ocular medications? _____
Are you allergic to any drugs or medications? _____
Are you allergic to any food? _____
Are you allergic to any soap, lotion, makeup, or skin product? _____
Are you currently taking aspirin or ibuprofen? _____
Have you recently undergone a skin peel? _____
What products do you use for skin care? _____
Do you get pigment or brown spots from an injury, insect bite or cut? _____

**Skin Type** (when exposed to the sun **<u>without protection</u>** for about 1 hour):

| | |
|---|---|
| ___ Always burns, never tans | Type I |
| ___Always burns, sometimes tans | Type II |
| ___Sometimes burns, sometimes tans | Type III |
| ___Always tans (American Indian) | Type IV |
| ___Hispanic, Asian, Mediterranean, Middle Eastern | Type V |
| ___African-American | Type VI |

When were you last exposed to the sun, including tanning booths? _____
Do you use chemical tanning solutions? _____ If so, what product? _____
Are you planning a holiday in the sun? _____ If so, when? _____
Have you ever had a Photo-Rejuvenation session?_____ If so, where? _____

**PLEASE CONTINUE TO NEXT PAGE**

# Confidential Medical History, Page 2

**Today's Date**: ____/____/____ **Birth Date**: ____/____/____ **Gender (F/M)**

**Name**: _____

**Do you have or have you had any of the following conditions (answer 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"
_____ Corneal Abrasions
_____ Eye Surgery or Injury
_____ Blepharoplasty (eyelid surgery)
_____ Visual Disturbances
_____ Cancer
_____ Tumors/Growths/Cysts
_____ Chemotherapy/Radiation
_____ Are you pregnant?
_____ Hepatitis
_____ Do you wear contact lenses? (Always take them out before facial procedures please.)
_____ Do you use tobacco products?

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

Examining Physician: _____

Have you been exposed to Waxing, Tweezing, or Bleaching? _____Date of last exposure_____
Have you taken any of the following products? (Circle)

Retin-A Differin Gel Alpha Hydroxy Acid Cumadin

Renova Accutane Glycolic Acid Salicylic Acid

Have you ever been treated for any of the following? (Circle)

Acne Depression Skin Disease High Blood Pressure Cancer

Diabetes Hormone Therapy Lupus Keloid Scarring

Additional information you would like us to know: _____
_____
_____
_____
_____
_____
_____
_____
_____

_____ _____
**Signature** **Date**