

MARILYN'S MAKE UP MAGIC
Medical History Form

Today's Date: _____ **Birth Date:** _____

Who referred you to "Make Up Magic" : _____

Your Name: _____ **Cell#:** _____ **Home#** _____

Home Address: _____ **City** _____ **State** __ **Zip** _____

→eMail Address: _____

Employer: _____ **Occupation:** _____

Work Address: _____ **City** _____ **State** __ **Zip** _____

Work Phone: _____ **Work/Home Fax:** _____

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 and phone number:

Physician: _____ **Phone Number:** _____

Emergency Contact: _____

Emergency Address & Phone #: _____

List all medications you are currently using including Retin A, Glycolic Acid and Acutane:

List medication, food allergies, or sensitivity to petroleum based products (i.e., Bacitracin): _____

_____ Are you allergic to Nickel or Latex Gloves? _____ Are you allergic to Lanolin? _____

Have you had Dermabrasion, chemical or Laser resurfacing of the face? _____ If yes, when was it done? _____

Have you ever had "fillers, injected into your lips? ___ Face? ___ If yes, when? ___ Do you have implants in your lips? ___

If yes, when? ___ Have you used cortisone or steroids in the last 6 months? Have you had an "eye lift" in the 1980's or before? _

Do you use tobacco products? ___ Do you wear removable dentures? Upper ___ Lower ___

Have you EVER had a cold sore or fever blister? ___ Are you pregnant? ___

Have you ever been told to pre-medicate for a dental procedure and if so, why? _____

Do you have or have you had any of the following conditions

- | | |
|---|----------------------------------|
| _____ Lens Implants | _____ Stroke |
| _____ Do you wear contact lenses? | _____ Prolonged Bleeding |
| _____ Have you ever worn hard contacts? | _____ Fainting Spells/Dizziness |
| _____ Radial Keratotomy | _____ Epilepsy |
| _____ Detached Retina | _____ Stomach Ulcers |
| _____ Glaucoma | _____ Venereal Disease |
| _____ Abnormal Heart Condition | _____ Thyroid Disturbances |
| _____ Heart Murmur | _____ Kidney Disease |
| _____ Mitral Valve Prolapse | _____ Diabetes |
| _____ Rheumatic Fever | _____ Liver Disease |
| _____ Artificial Heart Valves | _____ Tumors/Growths/Cysts |
| _____ Vascular Graft | _____ Cancer |
| _____ Pacemaker | _____ Chemotherapy/Radiation |
| _____ Prosthetic Hip or Joint | _____ Hepatitis (A, B, C) |
| _____ Anemia/Hemophilia | _____ Tuberculosis |
| _____ High Blood Pressure | _____ Circulatory Problems |
| _____ Low Blood Pressure | |

Signature _____
(rev 7/2010)

Today's Date _____

Make Up Magic Rep: _____