JOY A TOTAL BODY CARE SALON
6319 E. U.S. Hwy 36 Suite #4
AVON, IN 46123

MEDICAL HISTORY FORM

Todays Date:____/____/____ Birth Date:____/____/____

Name:_____

Home Address:_____

City/zip_____

Work Address:_____

City/zip_____

Home Phone(___)_____

Cell Phone(___)_____

Work Phone(___)_____

Employer:_____ Occupation_____

Referral name:_____

Are you now or have you been under the care of a physician within the last two years? YES NO

If yes pleaser provide the reason:_____

If yes please provide physician's name, address and phone number:_____

_____

_____

Person to contact in an emergency: Name:_____

Address:_____

_____

Phone #:_____

List all medications and vitamins you are currently taking:_____

_____

_____

Are you using skin products that contain Retin A, Glycolic Acid or AHA's: YES NO

List any drug, skin or food allergies:_____

Are you allergic to Epinephrine?	YES	NO
Are you allergic to latex or Novocaine?	YES	NO
Are you undergoing laser hair removal?	YES	NO
Are you currently undergoing any form of facial peels or microdermabrasion?	YES	NO
Are you pregnant?	YES	NO
Are you breast feeding?	YES	NO
Do you wear contact lenses?	YES	NO
Are you using any eye drops or other ocular medications?	YES	NO
So you use tobacco products?	YES	NO
Have you ever experienced hyper- pigmentation from an injury?	YES	NO
Are you currently taking aspirin, ibuprofen or blood thinners	YES	NO
Do you have implants or pins anywhere in your body?	YES	NO
Do you need to take an antibiotic before seeing a Dentist?	YES	NO

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING CONDITIONS (circle Yes or No)

YES	NO	Abnormal Heart Condition	YES	NO	Cancer
YES	NO	Cold Sores	YES	NO	Chemotherapy
YES	NO	High or Low Blood Pressure	YES	NO	Radiation
YES	NO	Circulatory Problems	YES	NO	Hepatitis
YES	NO	Diabetes	YES	NO	HIV
YES	NO	Cataracts	YES	NO	Hemophilia
YES	NO	Corneal Abrasions	YES	NO	Epilepsy
YES	NO	Blepharoplasty (eyelid surgery)	YES	NO	"Dry Eye"
YES	NO	Prolonged Bleeding	YES	NO	Eye Surgery
YES	NO	Tumors/Growths/Cysts	YES	NO	Visual Problems

Last eye exam?____/____/____

SIGNATURE:_____Date:_____