Medical History Form

Name:_____ Date:_____
Address:_____ Town/City:_____ Zip:_____
Email:_____
Phone/Cell:_____ Birthday:_____

List medications you are currently taking, including Retin A, Glycolic Acid & Accutane:
_____

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

Are your allergic to Acrylate/Cyanocarylate (bonding agents)?
Yes / No / Not Sure

Have you ever had a reaction to adhesive tape, topical creams, nail adhesives, or any other topical products?
Yes / No / Not Sure

These questions are relevant to your hair growth & overall hair health.

Do you wear contacts/glasses?
Yes/No

Do you visit the sauna/steam room?
Yes/No

Do you have or have you had any of the following conditions? (circle)

Alopecia	Dry Eye	Back Pain
Conjunctivitis	Sensitive Eyes	Claustrophobia
Light Sensitivity	Watery Eyes	Hormonal Imbalance
Recent Eye Surgery	Chemo	Blepharitis
Current Eye Irritation	Thyroid	