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MK Brows

2617 W Holcombe Blvd
Suite F, Studio 34
Houston, TX 77025

Medical History

First Name: _____ Last Name: _____

Home Address: _____ City/State/Zip: _____

Work Address: _____ City/State/Zip: _____

Home Phone: _____ Work Phone: _____

Are you now or have you been under the care of a physician within the last two years? ☐ Yes ☐ No
If yes, please provide physician's name, address, and phone number: _____

_____

Emergency Contact

Name: _____ Phone: _____

Street Address: _____ City/State/Zip: _____

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

_____

List your drug, makeup, skin, and/or food allergies (e.g. soaps or cleansing creams): _____

_____

Have you recently undergone a skin peel? ☐ Yes ☐ No

List products you use for skin care: _____

Do you have or have you had any of the following conditions? (check all that apply):

☐ Abnormal Heart Condition
☐ Cold Sores
☐ Herpes Simplex
☐ Hemophilia
☐ High or Low Blood Pressure
☐ Prolonged Bleeding
☐ Circulatory Problems
☐ Epilepsy
☐ Diabetes
☐ Feinting Spells/Dizziness
☐ Cataracts
☐ Glaucoma
☐ Dry Eye
☐ Corneal Abrasions
☐ Eye Surgery or Injury
☐ Blepharoplasty (eyelid surgery)
☐ Visual Disturbances
☐ Cancer
☐ Tumors/Growths/Cysts
☐ Chemotherapy/Radiation
☐ Hepatitis

Are you using eye drops or other ocular medications? ☐ Yes ☐ No

Do you wear contact lenses? ☐ Yes ☐ No

When was your last eye exam? _____/_____/_____ Examining Physician: _____

Are you currently taking aspirin or ibuprofen? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No

Do you use tobacco products? ☐ Yes ☐ No

Signature: _____ Date: _____