



MEDICAL HISTORY FOR LATISSE®

Name: _____ Sex: M F Today's Date: _____

Age: _____ DOB: _____

Latex Allergy: Yes No **Tape Allergy:** Yes No Specify kind _____

ALLERGIES to FOOD/DRUG: Yes No Please list below, indicating reaction

MEDICATIONS: List dosage or number of pills per day (use an additional sheet, if necessary)

Prescription Drugs

Non-Prescription (Vitamins: Herbs)

Regular Aspirin Use: Yes No Dosage Frequency: _____

NSAID (Advil, Motrin, and Ibuprofen): Yes No Dosage / Frequency: _____

Cortisone/Steroid Injections in the Past Year: Yes No Date(s) and injection location: _____

Smoke: Yes No Amount: _____ Coffee/Tea/Cola: Yes No Amount: _____

Alcohol: Yes No Amount: _____ Daily Exercise: Yes No Amount: _____

PERSONAL HISTORY: Please list any medical conditions you are currently being treated by a physician for:

date treatment began

physician treating

briefly describe the condition

I certify that the above information is correct and complete to the best of my knowledge. I will not hold my physician or his/her staff responsible for any errors or omissions that I may have made in the completion of this form. This will serve as authorization and consent for medical use of Latisse for hypotrichosis.

Patient Signature: _____

Date: _____

For Office Use Only
Reviewed by:

Date: