**LATISSE - EYE EVALUATION**

# MD Aesthetics

**First and Last Name (PRINT CLEARLY)**_____

**Your "Eye Doctor's" Name & Address**_____

_____ **Date of your last examination**_____

Have you ever been told you have glaucoma or increased pressure inside your eye? ☐ yes ☐ no

Are you presently taking, or have you taken any glaucoma medication(s)? ☐ yes ☐ no

If so what medication(s) are you taking?_____

At your last examination were you told you have problems with your eyes? ☐ yes ☐ no

Explain_____

Do you require glasses or contact lenses? (circle which)

Have you had any injuries or surgery to the eye or lids?

Explain_____

Are you bothered by frequent irritations or "allergies" of the eyes or lids? (Circle which)

Have you experienced eye itching, eye redness, and darkening of skin of eyelid, from the use of any eye products (prescribed or over the counter) ? ☐ yes ☐ no

Are you sensitive to any of the following products?

Benzalkonium Chloride ☐ yes ☐ no

*Sodium* Phosphate Dibasic ☐ yes ☐ no

Sodium Chloride ☐ yes ☐ no

Citric Acid ☐ yes ☐ no

Do you feel your eyes or lids swell excessively or become *irritated* easily? ☐ yes ☐ no

Do you now take or have ever taken medications or drops for the eyes? ☐ yes ☐ no

Explain_____

Are you bothered by "dry eyes?" ☐ yes ☐ no

Do your eyes "water" or tear spontaneously (without emotional stimulation)? ☐ yes ☐ no

Do you now have, or have you ever had any visual problems with one eye or both eyes? ☐ yes ☐ no

Explain _____

Are there any problems we have not asked about that you feel we should know? ☐ yes ☐ no

Explain _____

Are you pregnant or breast feeding? ☐ yes ☐ no

CHECK TO CONFIRM:

☐ I have been instructed and understand the 5 steps of how to apply Latisse

☐ *I* ***signify that to the best*** *of* ***my knowledge the information provided above is accurate.***

Please save and email to mda@mdaesthetics.ca