



Cosmetic Medical History

All questions contained in this questionnaire are strictly confidential and will become part of your medical record. All questions must be answered. Failure to do so will result in an inaccurate medical record and may affect your insurance processing. PLEASE ASK if you have any questions.

Date: ___/___/___

Your Name: (Last, First, MI) _____ Date of Birth: ___/___/___ Age: ___

How do you identify yourself: (Place an "X") Male ___ Female ___ Other ___

Pharmacy – Name: _____ Location: _____

PLEASE CIRCLE BELOW ALL MEDICAL DIAGNOSES YOU HAVE:

PAST MEDICAL HISTORY				
Diabetes	Heart Disease/Congestive Heart Failure	Hepatitis/Liver Disease	Hypertension (high blood pressure)	Kidney Disease
Migraines	Lung Disease	B12 deficiency	Restless Legs	HIV
Arterial Disease	Stroke	Cancer	Hole in your heart (Patent Foramen Ovale)	Pacemaker
Anemia	Lymphedema	Asthma	Arthritis	OTHER: _____

PLEASE CIRCLE THE ANSWER THAT FITS YOU – FEMALES ONLY:

PAST MEDICAL HISTORY: PREGNANCY/NURSING HISTORY						
QUESTION	ANSWERS					
1. Are you nursing?	Yes	No				
2. Are you planning more children?	Yes	No				
3. Are you Pregnant?	Yes	No	If yes, which Trimester?	First	Second	Third
4. How many pregnancies have you had?	# _____	How many C-sections?	# _____	How many Vaginal Deliveries?	# _____	
5. Have you had a blood clot from pregnancy?	Yes	No				

5. Do you use chewing tobacco?	Yes	No			
6. If you smoke:	What age did you start? age _____	How many packs per day? _____ packs/day	Have you thought about quitting?	Yes	No
7. If you are a FORMER Smoker:	How long did you smoke? _____ years	At what age did you start? age _____	How packs per day? _____ packs/day		
8. Marital Status?	Married	Unmarried	Divorced	Widowed	Other _____
9. Do you have children?	Yes	No	If yes, how many children? _____		

CURRENT MEDICATIONS (please include all over the counter and supplements)

Name	Strength	Frequency (how often)

ALLERGIES

Medication/Food	Type of reaction (rash, hives, etc.)	CIRCLE severity of reaction
		mild moderate severe
		mild moderate severe
		mild moderate severe
		mild moderate severe

FITZPATRICK CLASSIFICATION SYSTEM (Please **check** which applies)

Skin Type	Skin Color	Characteristics
___ I	White	Always burns, never tans
___ II	White	Usually burns, never tans
___ III	White	Sometimes mild burn, tans about average
___ IV	White	Rarely burns, tans more than average
___ V	Brown	Rarely burns, tans perfectly
___ VI	Black	Never burns, deeply pigmented

SKIN TYPE:

Does your skin ever flake or feel tight and dry? Frequently Occasionally Rarely

Is your skin shiny a few hours after cleansing? Frequently Occasionally Rarely

How often do you experience blackheads or blemishes? Frequently Occasionally Rarely

How noticeable are your pores? Very Not Very

For Microdermabrasion/HydraFacial:

Have you seen a dermatologist for your skin? []Yes []No

Have you ever had laser surgery, microdermabrasion or peels? []Yes []No If so, when? _____

What type of skin products are you using now? _____

Have you ever had Botox/Collagen fillers? []Yes []No If so, when? _____

Have you ever had skin cancer? If yes, where and what treatments? _____

For Hair Reduction/Electrolysis:

What color is the hair of concern: _____ What area needs treatment: _____

Do you shave? []Yes []No Do you pluck? []Yes []No Do you use a cream for hair removal? []Yes []No

For any skin conditions (redness, rosacea, pores, wrinkles, etc.):

Do you have rosacea? []Yes []No If yes, what have you tried and for how long? _____

Do you have acne? []Yes []No Is it cystic? []Yes []No Do you have scars? []Yes []No

What have you tried in the past?(creams, prescriptions, treatments, etc.)_____

What are you concerned about with your skin? (wrinkles, pores, dryness, oily, etc.)_____

What current products do you use on your skin (face wash, creams, etc – prescription and over the counter):

For Tattoo Removal:

When did you get your tattoo? _____ Location(s) on body of tattoo to be removed _____

Please circle Yes/No:

Black Tattoo	Ye s	N o	Keloid Scars	Ye s	N o	Tanning within the last 6 weeks	Ye s	N o	Did you have an allergic reaction to your tattoo?	Ye s	N o	Hypersensitivity to skin products	Ye s	N o
Color Tattoo	Ye s	N o	Hives	Ye s	N o	Use of acne products/drugs	Ye s	N o	Steroid use?	Ye s	N o	Skin infections	Ye s	N o
Professional Ink	Ye s	N o	Skin Cancer	Ye s	N o	Photo sensitizing substances	Ye s	N o	Any Previous Tattoo Removal	Ye s	N o	Homemade Ink	Ye s	N o

Waxing	Ye s	N o	Cold sores	Ye s	N o	Needle phobia?	Ye s	N o	Autoimmune medications?	Ye s	N o	Electrolysis to area	Ye s	N o
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For Microneedling with Radiofrequency (Secret RF):

What are your concerns? Acne, pores, wrinkles, scars, etc. _____

What other treatments have you have had to address your concerns? _____

Do you have a pacemaker? Yes or No (Circle one)

Have you had microneedling done before or do you use a device at home? _____

Do you want Nitrous for your treatment? (\$25 additional) Yes or No (Circle one)

For TruSculpt Treatments:

Are you looking for fat reduction or muscle building? _____

Areas you would like treated? Please circle below:

Lower Abdomen	Upper Abdomen	Right Flank	Left Flank
Back	Bra Bulge	Arms	Front of Legs
Back of Legs	Inner Thighs	Outer Thighs	Buttocks

Have you had treatments to these areas before? If yes, when: _____

Thank you for providing this important information about your medical history. Please be advised that completing preliminary health and insurance questionnaires does not establish a physician-patient relationship with this practice. Dr. Aggarwal and the staff will review your health history and conduct an initial evaluation to determine whether you are a suitable candidate and whether the practice will accept you as a patient.

Responsible Party Signature: _____ **Date:** _____

Relationship to Patient (if other than self): _____

Notes: _____

First Name: _____ Last Name: _____ M. Initial: _____

Date of Birth: _____ Sex: _____ S.S#: _____

Address: _____ City: _____ State: _____ Zip: _____

Marital Status: _____ Email: _____ Employer: _____

Home Phone: _____ Cell Phone: _____

Race*: Am. Indian Asian African American White Decline to Answer Other

Ethnicity: Hispanic or Latino Not Hispanic or Latino Decline to Answer **Language:** _____

Primary Insurance: _____ Secondary Insurance: _____

Policy Holder Name: _____ Policy Holder Name: _____

Policy Holder Date of Birth: _____ Policy Holder Date of Birth: _____

Do you have a co-pay Yes No If yes, Co-pay Amount: _____

Family Physician: _____ How did you hear about us?: _____

I hereby acknowledge that on _____ (date) I have reviewed the Notice of Privacy Practice and Financial Policy of Vein Care Center which sets for the ways in which my personal health information may be used or disclosed by Vein Care Center and acknowledges that I am financially responsible for payment of any balances due.

You may disclose my health information to any of the following persons (Ex: Doctors, Family, Employer, etc.):

The full copy of the Vein Care Center's Privacy Notice and financial policy are kept in the office. You may ask to review the full policies at any time.

Emergency Contact: _____ Phone: _____ Relationship: _____

I hereby do ___do not ___ give permission to The Vein Care Center to photograph the areas I would like treated, both before and after treatment. I understand these photographs will be used to monitor the progress of my treatments. I understand that if used for marketing or medical research purposes these photographs will not contain my name or other identifying information. I understand that I will not be entitled to any payment or other form of remuneration as a result of any use of the photographs.
I have read and fully understand and agree to the HIPAA, Financial and photography policies of this practice.



Patient Signature: _____

Date: _____