Vein Care Center
Laser Specialists

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	Cold Sores/Herpetic Lesions
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				
6. Are you taking birth control pills?	Yes	No	**If no, have you taken them in the past?**	Yes	No	

7. Are you taking Hormone Replacement Therapy?	Yes	No	**If no, have you taken them in the past?**	Yes	No	

PLEASE CIRCLE ALL THE CONDITIONS/SURGERIES YOU HAVE HAD (FEMALE CONTINUED):

Fibroids	Endometriosis	C-Section	Hysterectomy	Ovary Removal
Ovarian Cysts	Myomectomy	Uterine Ablation	OTHER: _____	

PAST SURGERIES – NON VEIN	
SURGERY	**YEAR**
PAST VEIN SURGERIES	
SURGERY (STRIPPING, LASER, ETC.)	**YEAR**

PLEASE PLACE AN "X" IN THE ANSWER THAT FITS YOUR FAMILY:

FAMILY HISTORY FOR VENOUS DISEASES					
CONDITION	**MOTHER**	**FATHER**	**BROTHER**	**SISTER**	**OTHER FAMILY**
Rosacea					
Acne					
Melanoma or skin cancers					

PLEASE FILL IN THE BLANKS AND CIRCLE THE ANSWER THAT FITS YOU:

SOCIAL HISTORY					
1. OCCUPATION:					
2. Are you retired?	Yes	No			
3. Do you drink alcohol?	Yes	No	**If yes, how many times have you had more than 4 drinks in one day in the past year?**	_____# of times more than 4 drinks in one day	
4. Do you smoke?	Yes	No	**If yes, do you smoke: (circle)**	less than 9 cig/day	Greater than 10 cig/day
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	Yes	No	Keloid Scars	Yes	No	Tanning within the last 6 weeks	Yes	No	Did you have an allergic reaction to your tattoo?	Yes	No	Hypersensitivity to skin products	Yes	No
Color Tattoo	Yes	No	Hives	Yes	No	Use of acne products/drugs	Yes	No	Steroid use?	Yes	No	Skin infections	Yes	No
Professional Ink	Yes	No	Skin Cancer	Yes	No	Photo sensitizing substances	Yes	No	Any Previous Tattoo Removal	Yes	No	Homemade Ink	Yes	No
Waxing	Yes	No	Cold sores	Yes	No	Needle phobia?	Yes	No	Autoimmune medications?	Yes	No	Electrolysis to area	Yes	No

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:_____

_____

_____

_____

_____

_____

_____

Vein Care Center
Laser Specialists

DEMOGRAPHICS

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

SS#:_____ Date of Birth:_____ Gender:_____

Marital Status:_____ Home Phone:_____ Cell Phone:_____

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

Email: _____ Emergency Contact Phone: _____

Emergency Contact Name: _____ Relationship:_____

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

Language:_____ Race: ☐White ☐Am. Indian ☐Asian ☐Other ☐Decline to Answer

Ethnicity: ☐African Am ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Decline to Answer

INSURANCE

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:_____

HIPPA AND FINANCIAL POLICY ACKNOWLEDGEMENT

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

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

_____

I have read and fully understand and agree to the HIPAA and Financial policies of this practice.

Patient Signature: _____ Date: _____