



Manu B. Aggarwal, M.D.

NO CHANGES TO MEDICAL HISTORY SINCE LAST VISIT.

NO CHANGES TO VEIN SYMPTOMS SINCE LAST VISIT.

PLEASE CHECK BOX AND RETURN FORM TO THE FRONT DESK. THANK YOU.

**MEDICAL HISTORY QUESTIONNAIRE
COSMETIC SERVICES**

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. PLEASE ASK if you have any questions.

Date:	<input type="checkbox"/> M <input type="checkbox"/> F	Birthdate:
Name <i>(Last, First, M.I.):</i>		Age:

MEDICATION/SURGERY CHANGES SINCE LAST VISIT:

ANY MEDICAL CONDITIONS NEWLY DIAGNOSED (Pregnancy, etc):

CHANGES TO VEIN/SKIN SYMPTOMS SINCE LAST VISIT:

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 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): _____