VEIN SPECIALTIES – Cosmetic Patient Profile

Today's Date:___________________

Name: ____ **DOB:** ____________________ **Sex:** _____________

Address: ____

Home Phone: ________________________ Cell: _________________________ Work: __________________________

Which phone number do you prefer we call? Home Cell Work

Email: ____

Do we have permission to send you emails regarding upcoming events and promotions? __________________________

How did you hear about us? (If person referral, who?) ____

Height: ______________________________________ **Weight**: ____

Medications currently taking (include herbal supplements):

________________________________ ________________________________ ________________________________

________________________________ ________________________________ ________________________________

Allergies (topical preparations, oral medications, or foods)? ____

<u>HISTORY</u>: (If YES, please describe)

Take aspirin, ibuprofen, Coumadin	YES	NO	______________________________
Pregnant or lactating; Attempting to get pregnant (please include number of pregnancies if applicable)	YES	NO	______________________________
Contraceptives use (oral, intrauterine, patch)	YES	NO	______________________________
History of fever blisters/cold sores	YES	NO	______________________________
History of keloid scarring	YES	NO	______________________________
Lesion removal (pre-cancerous, moles)	YES	NO	______________________________
Previous use of accutane	YES	NO	______________________________
Smoke or tobacco use	YES	NO	______________________________
History of tanning	YES	NO	______________________________
Sun exposure outdoors	YES	NO	______________________________
Skin conditions (Vitiligo, Psoriasis, etc)	YES	NO	______________________________
Are you currently under the care of a physician?	YES	NO	______________________________
Are you currently under the care of a dermatologist?	YES	NO	______________________________

Please list skin care regimen/products you are currently using (including Retin A/Retinol):

AM:_____________________________________ PM:_____________________________________

_______________________________________ _______________________________________

_______________________________________ _______________________________________

PREVIOUS PROCEDURES: If yes, please describe last treatment date and any details that may be helpful.

Procedure			
Spider vein treatments	YES	NO	________________________
Tattoo Removal	YES	NO	________________________
Chemical peels (glycolic, salicylic, TCA, etc)	YES	NO	________________________
Microdermabrasion	YES	NO	________________________
Botox/Dysport/Xeomin	YES	NO	________________________
Injectable Fillers (Restylane, Radiesse, etc)	YES	NO	________________________
Laser treatment(s)	YES	NO	________________________
Facial surgery	YES	NO	________________________

*Are you pleased with results? ____

Do you have any interest in learning about other services? (Check all that apply)

O Tattoo Removal

O Treatment of Spider Veins on Legs

O Improvement of Fine Lines & Wrinkles

O Skincare

O Cosmetic Improvement in Appearance of Hands

O Sun Spots

O Treatment of Facial Veins

O Treatment of Facial Redness (Rosacea)

O Botox, Xeomin, Dysport

O Injectable Fillers: Restylane, Perlane, Belotero, Radiesse

Tattoo Removal Details

How old is your tattoo?____

Where is your tattoo located? ____

Is your tattoo homemade or professional? ____

Has your tattoo ever been re-inked?	YES	NO	____________________
Have you ever had a reaction to a previous laser treatment, heat treatment, or radiation treatment?	YES	NO	____________________
Do currently have a sunburn?	YES	NO	____________________
Do you have hyperpigmentation (darkening of the skin) or hypopigmentation (lightening or absence of pigmentation of the skin) or marks after physical trauma?	YES	NO	____________________

Do you have any of the following medical conditions?

- o Cancer
- o Diabetes
- o Herpes
- o Arthritis
- o Frequent cold sores
- o HIV/AIDS
- o Seizure disorder
- o Hepatitis
- o Blood clotting abnormalities
- o Active infections

Do you have any other health problems or medical conditions? Please list: ______________________________

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