Atlantic Vein Institute

HEALTH HISTORY

PERSONAL INFORMATION

DATE: _____

LAST NAME:_____FIRST:_____M.I.:_____

STREET ADDRESS:_____CITY:_____STATE:_____ZIP:_____

HOME PHONE:_____WORK PHONE: _____

CELL:_____EMAIL:_____

DATE OF BIRTH (MONTH/DAY/YEAR):_____AGE:_____SEX: ☐ FEMALE ☐ MALE

WHERE DID YOU HEAR ABOUT US: (Please be specific)

INTERNET:_____REFERRAL:_____

ADVERTISEMENT:_____IF SO WHERE:_____OTHER: _____

I AM INTERESTED IN: (Please check all that apply)

- ☐ LEG VEIN TREATMENTS
- ☐ FACIAL VEIN TREATMENTS
- ☐ HAND VEIN TREATMENTS
- ☐ OTHER VEIN TREATMENTS
- ☐ ROSACEA/REDNESS
- ☐ SUN DAMAGE
- ☐ AGE SPOTS
- ☐ SKIN REVITALIZATION
- ☐ FINE LINES/WRINKLES
- ☐ ACNE TREATMENTS
- ☐ SKIN TAGS
- ☐ WARTS
- ☐ SCARS
- ☐ BRUISING
- ☐ HAIR REMOVAL
- ☐ OTHER, PLEASE SPECIFY _____

DO YOU USE SUNSCREEN? ☐YES, IF YES SPF #_____ ☐ NO

WHEN YOU SUNBATHE, HOW DOES YOUR SKIN RESPOND?

☐ ALWAYS BURN, NEVER TAN ☐ USUALLY BURN, TAN WITH DIFFICULTY ☐ SOMETIMES BURN, TAN ABOUT AVERAGE

☐ ALMOST NEVER BURN, TAN VERY EASILY ☐ RARELY BURN, TAN EASILY ☐ NEVER BURN, ALWAYS TAN

MEDICAL HISTORY: (Check the appropriate box next to any condition for which you have ever been treated)

- ☐ ACNE
- ☐ ARTHRITIS
- ☐ AUTOIMMUNE DISORDER
- ☐ BLOOD DISORDERS
- ☐ CANCER (OR RADIATION THERAPY)
- ☐ DIABETES / DIABETIC NEUROPATHY
- ☐ HERPES (OR COLD SORES)
- ☐ HIRSUTISM
- ☐ VITILIGO
- ☐ KIDNEY DISEASE
- ☐ MELANOMA
- ☐ PORT WINE STAIN
- ☐ PSORIASIS
- ☐ PACEMAKER
- ☐ SHINGLES
- ☐ SKIN PIGMENTATION ISSUES
- ☐ STEROID OR HORMONAL THERAPY
- ☐ HORMONAL IMBALANCES
- ☐ POLYCYSTIC OVARIAN SYNDROME
- ☐ KELOID SCARS / OTHER SCARS

ADDITIONAL QUESTIONS:

1 ARE YOU CURRENTLY BEING TREATED FOR ANY CONDITIONS NOT LISTED? IF YES, PLEASE SPECIFY.

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2 ARE YOU CURRENTLY TAKING ANY MEDICATIONS, INCLUDING ANTICOAGULANTS, HERBAL PREPARATIONS, MEDICAL PATCHES OR ASA? IF YES, PLEASE SPECIFY.

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3 DO YOU HAVE ANY ALLERGIES? IF YES, PLEASE SPECIFY.

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4 HAVE YOU EVER USED (OR ARE CURRENTLY USING) RETIN A OR GLYCOLIC ACID? IF YES, PLEASE SPECIFY.

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5 HAVE YOU EVER USED (OR ARE CURRENTLY USING) ACCUTANE/ROACCUTANE? IF YES, PLEASE SPECIFY.

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6 HAVE YOU EVER HAD A CHEMICAL PEEL? IF YES, PLEASE SPECIFY.

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7 HAVE YOU HAD ANY LASER TREATMENTS? IF YES, PLEASE SPECIFY.

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8 WHAT PRODUCTS ARE YOU CURRENTLY USING ON YOUR SKIN?

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9 DO YOU HAVE ANY DENTAL OR ACRYLIC IMPLANTS, CROWNS OR BRIDGEWORK? IF YES, PLEASE SPECIFY.

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10 DO YOU HAVE ANY TATTOOS OR PERMANENT MAKEUP IN THE AREA TO BE TREATED? IF YES, PLEASE SPECIFY.

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11 DO YOU HAVE A PACEMAKER?

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12 HAVE YOU EVER BEEN TREATED BY AN ENDOCRINOLOGIST (HORMONE IMBALANCE)?
IF YES, PLEASE SPECIFY.

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13 DO YOU SUNBATHE OR USE SELF TANNING LOTIONS OR USE TANNING BEDS? IF SO, THEN HOW OFTEN?

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14 HAVE YOU EVER HAD GOLD THERAPY (USED FOR RHEUMATOID ARTHRITIS)?

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15 ARE YOU CURRENTLY PREGNANT?

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16 HAVE YOU HAD FILLER OR BOTOX/DYSPORT INJECTIONS IN THE AREA TO BE TREATED?
IF YES, PLEASE SPECIFY.

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17 DO YOU HAVE ANY PARTICULAR SKIN SENSITIVITIES?

PLEASE SIGN BELOW TO INDICATE ALL THE INFORMATION ON THIS FORM IS ACCURATE AND COMPLETE.

SIGNATURE:_____ DATE: _____