Health History Questionnaire

GENERAL INFORMATION:

Full Name: _____ Sex: ◯ Female ◯ Male

Date of Birth: _____ Age: _____ Height: _____ Weight: _____ Occupation: _____

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

Employer: _____ Type of Work: _____ Email Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Marital Status: ◯ Married ◯ Divorced ◯ Single ◯ Widowed ◯ Seperated ◯ _____

Personal Physician: _____ ☐ MD ☐ DO ☐ ND ☐ Other

Pharmacy Name: _____ Phone Number: _____

ALLERGIES (medication, food, contact allergies) List what your reaction was and Date it happened?

_____

What are your concerns today? _____

How did you hear about us? ☐ Newspaper ☐ Radio ☐ Internet/Facebook ☐ Friend/Family

☐ Whom should we thank: _____

PERSONAL MEDICAL HISTORY (Please check/circle all that apply)

☐ Asthma / COPD / Bronchitis	☐ Anxiety/Depression Asthma	☐ Chronic Fatigue Syndrome
☐ Cancer (type) _____	☐ Cholesterol/Triglyceride (high)	☐ Colitis Crohn's Disease/Ulcers
☐ Melanoma/SCC/BCC Ulcers	☐ Fibromyalgia	☐ Eczema/Psoriasis/Melasma
☐ Pregnant/Breast Feeding	☐ Diabetes Type 1 Type 2	☐ Pacemaker/Irregular Heart Beat
☐ Autoimmune Disease/Lupus Heart Beat	☐ Menopause	☐ Headaches/Migraines
☐ Herpes/Cold Sores	☐ High Blood Pressure	☐ Hepatitis (A B C)
☐ Epilepsy/Seizures	☐ Heart Disease/MI/ACS	☐ Raynaud's Disease/Poor Circulation
☐ Neurological Disorder	☐ Polycystic Ovarian Disease/Hirsutism	☐ Syncope (fainting)/Low Blood
☐ Multiple Sclerosis	☐ Rheumatoid Arthritis/Arthritis	Pressure
☐ Guillain-Barre	☐ Thyroid (High) Low	☐ TMJ
☐ Lambert-Eaton		

MEDICATIONS (Please list all including topical prescription products, over the counter, supplements, herbs, Aspirin, Blood thinners etc)

Name	Dose	Frequency	Reason for Use

Any significant current illnesses? _____

Do you experience complications with: ☐ Healing ☐ Bleeding ☐ Bruising

Metal Implants in Body? Type and location: _____ ☐ Pacemaker ☐ Defibrillator

SURGERIES

Have you ever experienced an adverse reaction to a *cosmetic* or *laser procedure*? ◯ Yes ◯ No

If yes, please describe: _____

COSMETIC SURGERIES OR TREATMENTS

Procedure	Date	Physician/Location	Satisfaction (0-5)

FAMILY HISTORY (Please check all that apply)

☐ Skin Cancer and Melanoma	☐ Heart Disease	☐ Thyroid Disease
☐ Blood Disorder / Anemia	☐ High Blood Pressure	☐ Obesity
☐ Cancer (Type: _____)	☐ High Cholesterol / Triglycerides	☐ Other _____
☐ Diabetes	☐ Psychiatric Disorder	

SOCIAL BACKGROUND & HABITS

Exercise (type and frequency): _____

Alcohol? Number of drinks consumed per week: _____

Tobacco? ◯ No ◯ Yes ☐ Cigarettes / Packs per day: _____ Quit Date: _____

Tanning Habits: ☐ Tanning Bed ☐ Self Tanner ☐ Spray Tan ☐ Natural Tan Frequency? _____

FEMALE PATIENTS

Are you currently pregnant? ◯ Yes ◯ No Are you currently breast feeding ◯ Yes ◯ No

Are you planning to become pregnant during the course of your treatment? ◯ Yes ◯ No

PLEASE CHECK ALL YOUR CONCERNS OR INTERESTS:

☐ Mole Removal	☐ Wrinkles	☐ Hair Reduction	☐ Sun Damage	☐ Skin Tag Removal
☐ Redness	☐ Skin Care	☐ Waxing	☐ Spot Check	☐ Brown Spots
☐ Lash / Brow Tint	☐ Lumps / Bumps	☐ Melasma	☐ Black Heads	☐ Acne
☐ Dry Skin	☐ Crow's Feet	☐ White Heads	☐ Scars	☐ Chemical Peels
☐ Saggy Cheeks	☐ Skin Texture	☐ Rosacea	☐ Cherry Anginoma	☐ Thin Lips
☐ Eyelash	☐ Length / Volume	☐ Microdermabrasion	☐ Facials	☐ Spider Veins
☐ Hair Loss	☐ Oily Skin	☐ Skin Tone	☐ Aging Hands	☐ Lip Lines

I understand that Velum Skin and Laser center takes photographs of all treated areas before a procedure. These photos remain confidential and will only be used for treatment monitoring purposes.

I understand that it is my responsibility to notify MD or other Medical personal for any recent changes in medical history or medications.

I understand that there is a 24 hour cancelation policy, please be considerate

I realize that results may vary. I further understand that Velum Skin and Laser cannot prescribe an exact number of treatments to satisfy each individual's opinion and that the number of treatments I complete will be at my own discretion

Agreement to Proceed with Treatment:

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office. The consent will remain fully effective unless it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your health care provider about the purpose, potential risks, and benefits of any test/treatment/procedure ordered for you. If you have any concerns regarding any test/treatment/procedure recommended by your health care provider, we encourage you to ask questions.

You have voluntarily requested a physician, and/or mid-level provider and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing, treatment and procedures for the condition(s) which has (have) brought you to seek care at this practice. You fully understand that if additional testing, invasive or interventional procedures are recommended, you will be asked to read and sign additional consent forms prior to the test(s), treatment or procedure(s).

By signing below, you certify that you have read and fully understand the above statements and consent fully and voluntarily to their content.

Patient Signature: _____ Date: _____

Parent/Guardian Signature if under 18: _____ Date: _____

Witness Signature: _____ Date: _____