The Vascular Experts®
AESTHETICS

Name:_____
Birth Date:_____ Age:_____ Sex:_____
Address:_____
City_____ St_____ Zip_____
Phone: (Home)_____
Phone: (Cell)_____
Phone: (Work)_____
Email:_____
Language:_____ Race:_____ Ethnicity_____
Occupation:_____

Emergency Contact:
Name:_____
Phone:_____ Relationship:_____
Primary Care Physician:_____
Phone:_____
Referring Physician:_____
Phone:_____

How did you hear about us?
☐ MD referral ☐ Website ☐ Radio ☐ Event ☐ Newspaper ☐ Social Media
☐ Friend, list name for referral bonus _____

PATIENT CONCERNS

Spider Veins- Legs	Yes	No
Sun Damage	Yes	No
Facial Veins	Yes	No
Redness/Rosacea	Yes	No
Lines/Wrinkles	Yes	No
Acne	Yes	No
Uneven Skin Tone/Texture	Yes	No
Scarring	Yes	No
Brown Spots/Hyperpigmentation	Yes	No
Hair Removal	Yes	No

COSMETIC PROCEDURE HISTORY

Sclerotherapy (Leg Veins)	Yes	No
Laser Vein Therapy	Yes	No
Laser Photorejuvenation/IPL	Yes	No
Laser Hair Removal	Yes	No
Laser Skin Resurfacing/Tightening	Yes	No
Botox/Dysport	Yes	No
Peels/Microderms/facials	Yes	No
Dermal Fillers	Yes	No

Cosmetic Surgery _____ Year _____
Adverse Reaction to any of the above treatments? Yes No
_____
Were you pleased with your results? Yes No
_____

Which of the following best describes your skin when exposed to sun for 1 hour without SPF protection?
☐ Always Burns, Never Tans ☐ Rarely Burns, Always Tans
☐ Always Burns, Sometimes Tans ☐ Brown Skin
☐ Sometimes Burns, Always Tans ☐ Black Skin

Are you exposed to the sun, use a tanning salon, or tanning creams? Yes No
Date of your last exposure? _____
Do you use sunscreen? ☐ Never ☐ Sometimes ☐ Always
What products do you currently use on your face? _____
_____

MEDICAL HISTORY

Are you currently under the care of a physician or dermatologist for a medical problem? Yes No
If yes, please explain _____
_____

Do you have any of the following?
☐ Autoimmune Disease ☐ Hepatitis ☐ Varicose Veins
☐ Herpes or Cold sores ☐ Blood Clotting Disorder ☐ Cancer
☐ Anxiety/Depression ☐ HIV/AIDS ☐ Skin Disease
☐ High blood pressure ☐ Seizure Disorder ☐ Diabetes
☐ Thyroid Disease ☐ Synthetic/Metal Implants
☐ Neuromuscular Disorder/Bell's palsy

Allergies: Please list all medications, foods, seasonal &/or topical allergies and your reaction
_____
_____
_____

Medications: Please list all prescribed and over the counter
_____
_____
_____

Are you taking any of the following?

Anticoagulants	Yes	No
Accutane within last 12 mo	Yes	No
Immunosuppressant	Yes	No
NSAIDS/anti-inflammatories	Yes	No
Birth control	Yes	No
Steriods	Yes	No
Hormone replacement	Yes	No
Topicals- Retin-A/glycolic acid	Yes	No
Do you smoke?	Yes	No

If yes, how many packs/day? _____
Alcohol Intake: ☐ Never ☐ Occassional ☐ Weekly ☐ Daily

Female Patients: Are you pregnant?	Yes	No
If yes, are you breastfeeding?	Yes	No
Do you plan to become pregnant in the next year?	Yes	No