



Lori L. Greenwald, MD, FACS  
Medical Director

# The Aesthetic Center

DATE: \_\_\_\_\_

## MEDICAL HISTORY

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
Last First MI

Female  Male

How did you hear about Vanishing Veins and/or who referred you? \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Pharmacy (town and phone number): \_\_\_\_\_

### Do you have the following?

- Any active infection including fever, flu or cold symptoms .
- Use of photosensitive medication and/or herbs that may cause sensitivity to 515-1200 nm light exposure, such as isotretinoin (Accutane), tetracycline, or St. John's Wort.
- Exposure to sun or artificial tanning (including tanning creams and spray tan) during the 3-4 weeks prior to treatment.
- Have had sun exposure (i.e. vacation) in the last 3-4 weeks or planning on having sun exposure in the next 3-4 weeks.

Are you pregnant/lactating?  Yes  No

Do you wear contact lenses?  Yes  No

Do you have tattoos, including facial make-up?  Yes  No

### Past Medical History Do you have a history of any of the following?

Heart disease/heart attack/stress test	Yes	No	Cancer	Yes	No
Mitral valve prolapse	Yes	No	Thyroid	Yes	No
High blood pressure	Yes	No	Fear of Needles	Yes	No
Elevated cholesterol	Yes	No	History of fainting	Yes	No
Lung disease/asthma/bronchitis/emphysema	Yes	No	Blood Disorder	Yes	No
Tuberculosis (TB)	Yes	No	Clotting/Bleeding Disorder	Yes	No
Diabetes	Yes	No	Anemia	Yes	No
Liver disease/hepatitis	Yes	No	HIV/AIDS	Yes	No
Kidney disease	Yes	No	Skin rash/disease	Yes	No
Osteoporosis	Yes	No	Drug or Alcohol addiction	Yes	No
Systemic Lupus Erythematosus or Porphyrria	Yes	No	Herpes Simplex (including cold sores)	Yes	No
Amyotrophic lateral sclerosis	Yes	No	Myasthenia Gravis	Yes	No
Eaton Lambert Disorder	Yes	No	Multiple Sclerosis	Yes	No
Bells Palsy	Yes	No	Polycystic ovarian syndrome	Yes	No
Acne	Yes	No	Rosacea	Yes	No
Melasma	Yes	No	Eczema	Yes	No
Psoriasis	Yes	No			

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(OVER)



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**Review Of Symptoms Do you ever experience any of the following?**

Chest pain	Yes	No	Knee/Hip pain	Yes	No
Shortness of breath	Yes	No	Back Pain	Yes	No
Palpitations	Yes	No	Keloid/Excessive scarring	Yes	No
Irregular heart beat	Yes	No	Sudden weight loss or gain	Yes	No
Low blood pressure	Yes	No	Visual Problems	Yes	No
Seizures	Yes	No	Depression/Memory Loss	Yes	No
Frequent severe headaches	Yes	No	Ankle/feet swelling	Yes	No
Very dry skin	Yes	No			

**We want you to have the best treatment possible. If you have answered yes to any of the above, please explain in detail:** \_\_\_\_\_

**List other diseases or illnesses you have had and please explain:** \_\_\_\_\_

What medications, including herbal supplements and over-the-counter medications, are you taking?

No current medications

Allergies/Sensitivities:  No allergies

Have you ever been treated or are you being treated for a skin condition? If yes, what condition? \_\_\_\_\_

Have you had previous cosmetic procedures?:

- Facials/Peels       Waxing       Electrolysis       Depilatories (i.e. Nair)
- Microdermabrasion       Laser Hair Removal       Photofacial       Sclerotherapy
- Laser Spider Vein       Botox       Dermal filler injections
- Laser facial resurfacing

Please describe the type(s), frequency, and reaction(s): \_\_\_\_\_

**Skin Tone:**  Pale     Light Pink     Medium Pink     Light Olive     Dark Olive  
 Light Brown     Dark Brown     Soft Black     Black

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Skin Type:  Thick       Thin       Loose       Freckled       Uneven       Oily  
 Dry       Wrinkled       Rosacea       Eczema       Psoriasis       Sun Spots       Acne       Flush easily

Sun Exposure History:

Do you spend most of your day indoors? \_\_\_\_\_ Occupation: \_\_\_\_\_

Do you spend most of your leisure time outdoors? \_\_\_\_\_ Activities/Hobbies: \_\_\_\_\_

Do you currently, or have you ever, used a tanning booth? \_\_\_\_\_  
If yes, please describe frequency of use: \_\_\_\_\_

How often do you use sunscreen? \_\_\_\_\_

Describe your daily skin care regimen: \_\_\_\_\_  
\_\_\_\_\_

What makeup regimen are you currently using and what products do you use? \_\_\_\_\_  
\_\_\_\_\_

How can we help you today? \_\_\_\_\_

Are you doing this for a special occasion? \_\_\_\_\_

Have you ever had a consultation for this? If so, when? \_\_\_\_\_

Comments:  
\_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_

MD / PA-C / RN

5.6.08

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

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