VANDERVEER CENTER®

# Health History Questionnaire

## GENERAL INFORMATION:

Full Name: _____ Sex: ◯ Female ◯ Male

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

Occupation: _____ Employer: _____ Type of Work: _____

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

Children's Name: _____ Age: _____

Children's Name: _____ Age: _____

Children's Name: _____ Age: _____

## PERSONAL MEDICAL HISTORY (Please check all that apply)

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

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

| Name | Dose | Frequency | Reason for Use |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

In the last 12 months, have you experienced: ☐ Weight Gain? ☐ Weight Loss? Amount? _____ lbs.

Any significant current illnesses? _____

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

Metal Implants in Body(Including IUDs)? Type and location: _____ ☐ Pacemaker ☐ Defibrillator

## ALLERGIES (medication, food, contact allergies)

_____

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

**NON-COSMETIC SURGERIES (Please provide Year, Physician Name, and Type of Surgery)**

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

**Agreement to Proceed with Treatment:**

Although extremely rare, your treatment might result in the need for medical follow-up. We want you to report any concerns about your treatment to us immediately and if indicated, we will ask you to come to our office within 48 hours to be seen. We will instruct you to adhere to our recommended treatment plan for your follow-up care, provided at no charge to you. These visits will include clinical photography. You may choose to receive medical care elsewhere (e.g; your primary care physician) as well, but this will not replace the care you receive at VanderVeer Center, & agree to release those medical records to VanderVeer Center if requested.

I hereby certify that the foregoing information is accurate and complete and that I will notify the office of any changes in a timely manner. I will not hold the doctor, or any other member of the staff, responsible for any errors or omissions that I may have made in completion of this form.

Patient Signature: _____ Date: _____

Treatment Provider Signature: _____ Date: _____

MD Signature: _____ Date: _____

*IN OFFICE USE ONLY*

Reviewed with patient by: _____ Date: _____

Reviewed with patient by: _____ Date: _____