



Health History Questionnaire

General Information

Full Name _____ Sex: Female Male
 Date of Birth: _____ Age: _____ Height: _____ Weight: _____ Preferred Pronoun: _____
 Emergency Contact Name: _____ Relationship: _____
 Emergency Contact Cell #: _____ Work #: _____

Personal Medical History (Please check all that apply)

<input type="checkbox"/> Anxiety / Depression	<input type="checkbox"/> Hepatitis (<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C)	<input type="checkbox"/> Rheumatoid Arthritis / Arthritis
<input type="checkbox"/> Cancer (type _____)	<input type="checkbox"/> Herpes / Cold Sores	Other _____
<input type="checkbox"/> Diabetes (<input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2)	<input type="checkbox"/> Neurological Disorder _____	Other _____
<input type="checkbox"/> Eczema / Psoriasis / Melasma	<input type="checkbox"/> Multiple Sclerosis	Other _____
<input type="checkbox"/> Headaches / Migraines	<input type="checkbox"/> Raynaud's Disease/Poor Circulation	Other _____
<input type="checkbox"/> Thyroid (<input type="checkbox"/> Low <input type="checkbox"/> High)	<input type="checkbox"/> Autoimmune Disease/ Lupus	Other _____

Medications / Supplements

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

Name	Dose	Frequency	Reason For Use

In the last 12 months have you experienced: Weight gain? Weight Loss? Amount in lbs _____

Any significant current/recent illnesses? _____

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

Any metal implants in the body? Type _____ Location _____

Type _____ Location _____

Do you have a Pacemaker? or Defibrillator?

Allergies (medication, food, contact allergies):

Non-Cosmetic Surgeries (Please provide Year and Type of Surgery)

Year	Type of Surgery

Cosmetic Surgeries or Treatments

Procedure	Date	Satisfaction (0 – 5)

Have you experienced any adverse reactions to a cosmetic or laser procedure? Yes No

If Yes, please describe: _____

Female Patients

Are you currently pregnant? Yes No Are you currently breastfeeding? Yes No

Are you planning on becoming pregnant during the course of this 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, and 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 or Authorized Signer for Minor Patient

Date

Treatment Provider Signature

Date

Medical Director Signature

Date