VANDERVEER CENTER®

Health History Questionnaire

General Information

Full Name _____ Sex: ☐ Female ☐ Male

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

Emergency Contact Name:_____ Relationship:_____

Emergency Contact Cell #:_____ Work #:_____

Personal Medical History (Please check all that apply)

☐Anxiety / Depression	☐Hepatitis (☐A ☐B ☐C)	☐Rheumatoid Arthritis / Arthritis
☐Cancer (type_____)	☐Herpes / Cold Sores	Other _____
☐Diabetes (☐Type 1 ☐Type 2)	☐Neurological Disorder _____	Other _____
☐Eczema / Psoriasis / Melasma	☐Multiple Sclerosis	Other _____
☐Headaches / Migraines	☐Raynaud's Disease/Poor Circulation	Other _____
☐Thyroid (☐Low ☐High)	☐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