Chesapeake Vein Center & MedSpa
300 Medical Parkway Suite 208
Chesapeake, VA 23320
757-819-7633

Medical History

Name: _____

Address: _____

Phone #1: _____ **Phone #2:** _____

Female ☐ **Male** ☐ **Age:** _____ **Referred by:** _____

Email Address:

Reason for consultation

- ☐ Acne/ Acne Scars
- ☐ Brown spots or sun damage
- ☐ Enlarged blood vessels
- ☐ Fine lines or wrinkle
- ☐ Flushing of the skin
- ☐ Skin laxity/ texture
- ☐ Unwanted hair
- ☐ CoolSculpting

What other services are you interested in learning about during your consultation? (Please check all that apply)

- ☐ Skin care advice
- ☐ Skin care products
- ☐ Botox
- ☐ Juvederm
- ☐ Wrinkle Treatments
- ☐ Sun spots
- ☐ Broken blood vessels
- ☐ Blotchy skin
- ☐ Hair Removal
- ☐ Rosacea
- ☐ Acne scars
- ☐ Lengthening eyelashes

Other (Please explain):

_____

_____\

Questions about skin

1. How long have you been concerned about this area(s)? _____
2. At what age did you notice this concern(s)? _____
3. Are your present skin concern(s) getting more pronounced? ☐ Yes ☐ No
4. Have you ever been treated for this concern(s)? ☐ Yes ☐ No

   If yes, when? _____

   What method? _____

   Were you happy with results? _____
5. Are you currently taking medication for your skin's concern(s)? ☐ Yes ☐ No

   If yes, what is it? _____

6. What skincare products are you currently using? _____

7. What topical skin medications or products are you currently taking?

☐ Retin-A® ☐ Hydroquinone or bleaching agent ☐ Other _____

8. Have you ever had laser / IPL hair removal? ☐ Yes ☐ No

9. Have you ever used the following hair removal methods in the past 6 weeks?

☐ shaving ☐ waxing ☐ electrolysis ☐ plucking/tweezing ☐ stringing ☐ depilatories

9. Have you ever had skin resurfacing or rejuvenation or chemical peels? ☐ Yes ☐ No

10. Have you ever had treatments for pigmented lesions? ☐ Yes ☐ No

11. Do you form thick or raised scars (keloids) from cut or burns? ☐ Yes ☐ No

12. Do you experience hyperpigmentation (redness) from burns, cuts, insect bites? ☐ Yes ☐ No

13. Have you had cold sores or fever blisters? ☐ Yes ☐ No

Skin Type choices (when exposed to the sun for about 1 hour with no protection):

Always burns, never tans	☐	Rarely, burns, always tans	☐
Always burns, sometimes tans	☐	Brown, moderately pigmented skin	☐
Sometimes burns, always tans	☐	Black skin	☐

When were you last exposed to the sun or tanning booth? _____

1. Do you use self tanners? ☐ Yes ☐ No
2. Are you planning a vacation in the sun? ☐ Yes ☐ No

Personal history:

1. Do you smoke? ☐ Yes ☐ No if yes _____ packs per day
2. What is your daily consumption of alcohol? _____
3. Do you wear contact lenses? ☐ Yes ☐ No

Medical history:

1. Are you currently under the care of a physician? ☐ Yes ☐ No. If yes, for what:

_____

2. Do you have any of the following?

☐ Arthritis	☐ Epilepsy or seizures	☐ HIV / Aids
☐ Any active infection	☐ Heart disease	☐ MRSA
☐ Bleeding disorders	☐ Hepatitis	☐ Sensitive teeth
☐ Bruising	☐ Herpes simplex	☐ Skin cancer or moles
☐ Dark spots of pregnancy	☐ High blood pressure	☐ Skin injury
☐ Diabetes	☐ Hormone imbalance	☐ Vision deficits

☐ Other_____

3. Do you have allergies to any of the following? (check all that apply)

☐ medications ☐ latex ☐ food ☐ plants ☐ anesthesia ☐ other_____

4. Do you take any of the following?

☐ Accutane	☐ Appetite depressants	☐ Insulin
☐ Antibiotics	☐ Aspirin or Ibuprofen	☐ Sedatives
☐ Anti-coagulants	☐ Cortisone or steroids	☐ Thyroid medication
☐ Anti-depressants	☐ Hormone/contraceptives	☐ Other____

5. Are you taking herbal preparations or vitamins? (St. John's Wort, Vitamin E) ☐ Yes ☐ No

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For female patients:

1. Are you pregnant or trying to become pregnant? ☐ Yes ☐ No
2. Are you breast feeding? ☐ Yes ☐ No

I have answered the questions contained in this questionnaire to the best of my knowledge. I understand that it is my responsibility to inform my practitioner of my current health conditions while seeking treatment as a patient. I will update this information as it occurs.

Signature: _____ **Date:** _____