Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone:

Home: _____ Work: _____ Cell: _____

Email: _____

Age: _____ Date of Birth: _____ Marital Status: _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____

Phone:

Home: _____ Work: _____ Cell: _____

_____

Referred By: (check all that apply)

Physician (name) _____ Friend/Patient (name) _____

Newspaper _____ Magazine _____ Web Site _____
Other:_____

Reason for Visit: (check all that apply)

Vein Problems _____ Skin Rejuvenation _____ Laser Hair Removal _____

Botox/Xeomin _____ Dermal Fillers _____ Other _____

The Vein Center of South Carolina

Medical History

Full Name:
_____
Date of Birth: _____

Medication(s): *prescription and over the counter medications (vitamins, herbals, etc.)

_____
_____
_____
_____

Allergies: (drugs, topical preparations, latex, tape, etc.)

_____
_____
_____

General Information: (yes/no)

Do you smoke? _____ If so, how much? _____
Do you drink alcohol? _____ If so, how much? _____
Do you exercise? _____ If so, how much? _____

Are you on any type of diet or weight loss plan? _____
Had facial laser resurfacing/deep chemical peeling, last 3 months? _____
Had needle epilation, waxing, or tweezing, last six weeks? _____
Have any tattoos or permanent makeup? _____
Recent sun burn or tan? _____

Female Patients: (yes/no)
Is there **any** chance you could be pregnant? _____ Are you nursing? _____

Do you plan on becoming pregnant in the near future? _____ Using birth control? _____

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Medical History (continued)

Please check all that apply (current or prior)

_____ Accutane (last 6 mos)
_____ Angina
_____ Asthma
_____ Auto-Immune Disorders
_____ Bleeding Problems
_____ Blood Clots
_____ Bronchitis
_____ Cancer History
_____ Cold/Numb Feet
_____ Cold Sores/Fever Blisters
_____ Current Infection
_____Diabetes
_____ Headaches/Migraines
_____Heart Attack/Problems
_____Hepatitis
_____ High Blood Pressure
_____ HIV/AIDS
_____ Joint Pain
_____ Keloid Scarring
_____ Leg Pain
_____ Liver Problems
_____ Lupus
_____ Mental Disorders
_____ Neuro-Muscular Disorders
_____ Open Wounds
_____ Pacemaker/Defibrillator
_____ Phlebitis
_____ Photo Sensitivity
_____ Rashes
_____ Seizures
_____ Skin Infection (i.e. psoriasis, eczema)
_____ Spider Veins
_____ Stroke
_____ Sores/Ulcers on Legs
_____ Varicose Veins

Surgical History:

_____
_____
_____
_____

Any Additional Problems:

_____

_____

_____

_____

All information provided is true and accurate to the best of my knowledge.

_____

_____

Patient Signature Date