Vein Center of South Carolina

Patient Information

Name: _____ Date: _____

Address: _____

City _____ State _____ Zip Code _____

Phone:

Home _____ Work _____ Cell _____

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

Employer: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____

Phone:

Home _____ Work _____ Cell _____

E-mail: _____

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® _____ Dermal Fillers _____

Vein Center of South Carolina
Medical History

Full Name: _____

Date of Birth: _____

Medication: (prescription and over the counter medications; vitamins, herbals)

_____
_____
_____

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

_____
_____

General Information: (yes/no)

Do you smoke? _____ If so, how much? _____

Drink alcohol? _____ If so, how much? _____

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: (answer yes or 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? _____

(continue to next page)

Vein Center 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

____ Kidney Problems

____ Leg Pain

____ Liver Problems

____ Lupus

____ Mental Disorders

____ Neuro-Muscular Disorders

____ Open Wounds

____ Pacemaker/Defibrillator

____ Phlebitis

____ Photo Sensitivity

____ Rashes

____ Seizures

____ Skin Infection (ie 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