AESTHETIC LASER & VEIN CENTER OF NORTH BAY

Client Information and Medical History

PERSONAL HISTORY

Name_____Date_____
Date of Birth_____ Occupation_____
Home Address_____
City_____ State_____ Zip Code_____
Home Phone (__)_____Work Phone (__)_____Cell Phone (__)_____
May we call you at work? __yes __no
E-mail address: _____
Emergency Contact Name_____ Phone (____)_____
How did you hear about us?
Which of the following best describes your skin type? (Please circle)

I	Always burns, never tans
II	Always burns, sometimes tans
III	Sometimes burns, always tans
IV	Rarely burns, always tans
V	Brown, moderately pigmented skin
VI	Black skin

MEDICAL HISTORY:

Do You Smoke? Yes ( ) No ( )

Are you presently under the care of a physician? ( ) Yes ( ) no name_____
Are you presently under the care of a dermatologist? ( ) yes ( )no name_____

Do you have any of the following medical conditions? (Please check all that apply)
( ) keloid scarring ( ) skin disease/skin lesions ( ) Rosacea
( ) Herpes simplex or cold sores ( ) respiratory problems
( ) diabetes ( ) high blood pressure ( ) heart disease
( ) cancer ( ) Hepatitis/liver disease ( ) kidney diseases ( ) seizure disorder
( ) allergy to cold environment, Raynaud's disease, lupus, or other autoimmune diseases
( ) hormone imbalance ( ) thyroid imbalance ( ) blood clotting abnormalities
( ) any active infection ( ) history of consulting a psychiatrist or counselor
( ) personal or family history of anesthesia problems ( ) panic attacks ( ) fainting
Description of any of above problems _____
_____
Do you have any other health problems or medical conditions? Please list: _____

Medications: ( ) Accutane ( ) birth control ( ) hormones
( ) others, please list:_____
( ) homeopathic Rx (i.e. St. John's Wort, Gingko) _____

Do you take any pre-medication for dental or other procedures? (i.e. antibiotics)
__yes __no

Have you ever used Accutane? ( ) Yes ( ) No If yes, when did you last use it?_____

What topical medications or creams are you using?
( ) Retin A ( ) others, please list _____

Any recent tanning or sun exposure that changed the color of your skin? ( ) Yes ( ) No
Have you used any self-tanning lotions or treatments? ( ) Yes ( ) No

Do you have hyperpigmentation (darkening of the skin) or hypopigmentation (lightening of the skin) or marks after physical trauma ( ) Yes ( ) No If yes, please describe _____ _____.
Do you form thick or raised scars from cut or burns? ( ) Yes ( ) No

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FEMALE PATIENTS

Are you pregnant or trying to become pregnant? __yes __no
Are you using contraception? __yes __no
Are you breast-feeding? __yes __no

ALLERGIES
Have you ever had an allergic reaction to any of the following? (Please check all that apply and describe the reaction you experienced.) ( ) food ( ) latex ( ) cosmetics ( ) aspirin ( ) lidocaine ( ) hydrocortisone ( ) hydroquinone or skin bleaching agents ( ) other medications: _____

I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the technician, esthetician, therapist, nurse or doctor of any current medical or health conditions and to update this history as current medical history is essential for the caregiver to execute appropriate treatment procedures.
Signature_____ Date _____

I understand that professional services provided by Dr. Walter Tom and his staff will not be covered by medical insurance. I agree to take full responsibility for payment of the charges incurred.
Signature_____ Date _____

Advanced Directives: *ALVC respects your right to participate in decisions regarding your healthcare. However, the policy of the Center is that all patients undergoing procedures will be considered for life sustaining treatment.* ***ALVC does not honor advanced directives****. ALVC will always attempt to resuscitate a patient and transfer that patient to a hospital in the event of deterioration.*

Signature_____ Date _____