CORONADO
VEIN CENTER

Cosmetic Procedure Questionnaire

First Name: _____ Middle Initial _____

Last Name: _____ Sex: M F

Date of Birth: ____/____/____

Mailing Address: _____

_____

Email Address: _____

Phone Number: Home: _____ Mobile: _____

Work: _____

Family Doctor: _____ Phone: _____

Pharmacy: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Which body area(s) or condition(s) would you like treated? _____

_____

_____

Please answer all of the following questions:

Do you have ANY current or chronic medical illnesses? Yes / No

Disclose any history of heat uticaria, diabetes, autoimmune disorders or any immunosuppression, blood disorders, cancer, bacterial or viral infections, medical conditions that significantly compromise the healing response, skin photosensitivity disorders, or any other condition or illness.

Please list: _____

_____

Do you have ANY current or chronic skin conditions Yes / No

Disclose any history of vitiligo, eczema, melasma, psoriasis, allergic dermatitis, any diseases affecting collagen including Ehlers-Danlos syndrome, scleroderma, skin cancer or any other skin condition.

Please list: _____

_____

Are you currently under a doctor's care? If so, for what reason? Yes / No

Please list: _____

_____

Please list all medications, prescriptions, vitamins & supplements that you take on a regular basis. Specifically list any topical agents, both prescribed and over the counter, oral steriods, and any medication or supplement that may cause sensitivity to light.

Medication/Agent	Dose/Frequency

Do you havce ANY allergies to medications, foods, or other substances? Yes / No

Please list: _____

(Women) Are you, or could you be pregnant or breasfeeding? Yes / No

(Women) Are your menstrual periods regular, or have you ever been dignosed with Polycystic Ovarian Disorder? Yes / No

Do you have a history of herpes I or II in the area being treated? Yes / No

Do you have a history of keloid scarring or hypertrophic scar formation? Yes / No

Do you have a history of light induced seizures? Yes / No

Do you have any open sores or lesions? Yes / No

Do you have any history of radiation in the area to be treated? Yes / No

In the last six (6) months, have you used any of the following: anticoagulants or blood-thinning medications; photosensitizing or anti-inflammatory medications? Yes / No

Please list name and date of last use: _____

In the last three (3) months, have you used any of the following products: glycolic acid or otheralphahydroxy or betahydroxy acid products; exfoliating or resurfacing products or treatments? Yes / No

Please list name and date of last use: _____

Do you have or have you ever had any permanent makeup, tattoos, implants, or fillers? Yes / No

Please list location on/in body and date: _____

Do you have or have you ever had any botulinums, such as Botox®, etc? Yes / No

Please list location on/in body and date: _____

Have you taken Accutane® (or products containing isotretinoin) in the last 12 months? Yes / No

Have you taken Tretinoin (like Retin-A® or Renova®) in the last 6 months? Yes / No

Have you had any unprotected sun exposure, used tanning creams (including sunless tanning lotions) or tanning beds or lamps in the last 4-6 weeks? Yes / No

_____ _____

Signature Date