VITA

• Ageless Medical Aesthetics •

PATIENT INFORMATION AND MEDICAL HISTORY

In order to provide you with the most appropriate treatment, we need you to complete the following questionnaire. All information is strictly confidential.

First Name _____ Last Name _____

Date of Birth _____/_____/_____ Age _____ Occupation _____

Address _____ City _____ State ____ ZIP _____

Tel (____) _____-_____ Cell (____) _____-_____ E-mail _____

Treatment you are interested in: _____ How did you hear about us? _____

Emergency contact Name and Phone _____

MEDICAL EVALUATION AND HISTORY

Are you under the care of a physician? _____ reason _____

Name and number of your physician _____

Medications, Vitamins, Supplements you are taking: _____

List past Surgeries and dates _____ Any complications from surgery? _____

Have you taken Aspirin? _____ Dosage _____ Have you taken Accutane over the past year? _____

List any drug allergies (Lidocaine, Codeine, etc) _____

Tape, Latex, Adhesive allergies? _____ Other allergies _____

PLEASE MARK YES OR NO TO THE FOLLOWING QUESTIONS

EYES

Visual loss (one or both eyes)	☐YES	☐NO	Dry Eyes	☐YES	☐NO
Itching or irritation	☐YES	☐NO	Cornea problems	☐YES	☐NO
Wear glasses or contacts	☐YES	☐NO	Thyroid eye disease	☐YES	☐NO

NOSE

Difficulty breathing	☐YES	☐NO	Previous Injury	☐YES	☐NO
Nasal allergies or Sinus condition	☐YES	☐NO	Nose bleeds	☐YES	☐NO

FACE

Irradiation to face or neck	☐YES	☐NO	Facial skin problems	☐YES	☐NO
Facial paralysis or weakness	☐YES	☐NO	History of Cold Sore	☐YES	☐NO

CARDIOVASCULAR

Coronary or heart attack	☐YES	☐NO	Heart Murmur	☐YES	☐NO
Congenital heart disease	☐YES	☐NO	Stroke	☐YES	☐NO
Palpitations or irregular beat	☐YES	☐NO	Hypertension	☐YES	☐NO

CHEST

Shortness of breath	☐YES	☐NO	Chronic cough	☐YES	☐NO
Chronic lung disease	☐YES	☐NO	Asthma	☐YES	☐NO

OTHER MEDICAL CONDITIONS

Stomach problems or ulcers	☐YES	☐NO	Thyroid problems	☐YES	☐NO
Seizures, convulsions	☐YES	☐NO	Liver disorder (hepatitis, cirrhosis)	☐YES	☐NO
Spinal or back disorders	☐YES	☐NO	Kidney or bladder disorder	☐YES	☐NO
Chronic Infections	☐YES	☐NO	HIV or AIDS	☐YES	☐NO
Blood Clots, Thrombophlebitis	☐YES	☐NO	Diabetes	☐YES	☐NO
Cancer	☐YES	☐NO	Autoimmune disease	☐YES	☐NO
Communicable disease* (such as tuberculosis)	☐YES	☐NO	Other _____		

PSYCHOLOGICAL AND SOCIAL

Any recent crisis in your life? _____ Have you received psychological/psychiatric treatment? _____

Are you taking mood altering or anti-depression medications? _____ Do you have Claustrophobia? _____

Do you Smoke? _____ Packs per day_____ Do you drink more than 2 alcoholic beverages per day? _____

FOR FEMALE PATIENTS ONLY

Are you pregnant or trying to become pregnant? _____ Are you breastfeeding? _____

Are you using contraception? _____ What type? _____

SKIN -Circle one:

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

Scarring/Keloid	☐YES ☐NO	Acne	☐YES ☐NO	Easy bruising	☐YES ☐NO
Sun sensitivity	☐YES ☐NO	Eczema	☐YES ☐NO	Cold sores	☐YES ☐NO
Fine lines/wrinkles	☐YES ☐NO	Skin Flushing	☐YES ☐NO	Skin Infection	☐YES ☐NO
Hyperpigmentation (dark spots)	☐YES ☐NO ☐NO	Hypopigmentation (light spots)	☐YES ☐NO	Tattoos	☐YES ☐NO

Other Problems or concerns: _____ Recent tanning/sun exposure?_____

Do you wear sunblock? _____ Do you use any hair removal method? _____ which one?_____

I certify that the information I have given is true and accurate. It is my responsibility to inform the VITA professionals of my current medical condition and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Patient Signature _____ Date _____/_____/_____

If patient is a minor (under 18 years old) the Parent / Legal Guardian authorization is required:

Parent / Legal Guardian Signature: _____ Date: ____/____/____

Printed Name: _____ Relationship _____