Victoria Vein & Surgery Clinic- Tattoo Procedures
Medical History Form

CLIENT INFORMATION & MEDICAL HISTORY

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

PERSONAL HISTORY

Client Name _____ Today's Date _____

Date of Birth_____Age_____Occupation_____

Home Address_____ City_____ State____Zip _____

Home Phone (_____)_____ Cell Phone (____)_____

Emergency Contact Name and Phone_____

How did you hear about us? Please circle one

INTERNET SEARCH (Google / Yahoo / MSN): Search Term Used: _____

RADIO NEWSPAPER MAGAZINE www.VEINANDSURGERYCLINIC.COM HEALTH FAIR

OTHER: _____ REFERRED BY: _____

Which of the following best describes your skin type? (Please circle one type number)

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

How old is your tattoo?_____Is it homemade or professional? _____

MEDICAL HISTORY

Are you currently under the care of a physician? ❑Yes ❑ No If yes, for what:_____

Are you currently under the care of a dermatologist? ❑Yes ❑No If yes, for what:_____

Have you ever had a reaction to a previous laser treatment, heat treatment or radiation therapy? ❑Yes ❑No

Do you have any of the following medical conditions? (Please check all that apply)

❑Cancer ❑Diabetes ❑Herpes ❑Arthritis ❑Frequent cold sores ❑HIV/AIDS ❑Keloid scarring ❑Skin disease/Skin lesions ❑Seizure disorder ❑Hepatitis ❑Blood clotting abnormalities ❑Any active infection

Do you have any other health problems or medical conditions? Please list: _____

MEDICATIONS

What oral medications are you presently taking? Please List: _____

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

What topical medications or creams are you currently using? ❑ Retin-A® ❑Others (Please list): _____

Have you ever had an allergic reaction to any medication? Please List: _____

HISTORY

Do you currently have a sunburn? ❑Yes ❑No

Do you form thick or raised scars from cuts or burns? ❑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: _____

For our female clients:

Are you pregnant or trying to become pregnant? ❑Yes ❑No Are you breastfeeding? ❑Yes ❑No Are you using contraception? ❑Yes ❑No

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, doctor or nurse of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Signature_____ Date:_____