Thank you for choosing Premier Vein & Body and the office of Dr. Craig Schwartz. In order for us to fully understand your needs, we greatly appreciate your taking a moment to answer the following questions about your health and habits. All information will be held in strictest confidence.

Patient Information

Name:____ Date:____________________

Date of Birth:____________________ Age:__________

Address:______________________________ City:__________________________________

State:____ ________________________ Zip:________________________

Cell #:____________________Home #:_________________________Work #:___________________

Email:_________________________________Preferred method of contact:____________________

Can leave a message at: Home:_________Work:________Cell:_________Email:_______

Employer:____Occupation:_____________________

Emergency Contact Name & Number:____

Height________________ Weight___________________

Do you drink Alcoholic beverages?:__Y / N__ *If yes, how frequently:*________________________

Do you Smoke?:__Y / N__ *If yes, how frequently*____

How much water do you drink daily?:____

Are you pregnant or trying to become so?:__Y / N__

Family Doctor:________________________________ ______________________________________

Pharmacy Name & Number:____

Procedures or products of interest to you: (Check all that apply)

_______Acne Treatments _______Skin Photo-rejuvenation _______Micro-Laser Peels

_______miraPeel _______Botox®/ Xeomin® _______Radiesse®, Juvederm®

_______PicoSure® *Tattoo removal*

_______PicoSure® *Focus Rejuvenation*

Body Contouring/Skin Tightening:

_______Tickle Lipo

_______Venus Freeze/Venus Viva™

_______SculpSure™ _______CoolSculpting®

Sweating/Hair Removal:

_______miraDry/miraSmooth

Have you ever received any treatments on the previous page?
If so, please list…____

____

What type of problem are you consulting for:

____Sun Spots ____Wrinkles ____Enlarged blood vessels

____Flushing of the skin ____Large pores ____Sweating

____Body contouring ____Cellulite

____Other:____

How many years have you noticed this problem?______________________________

At what age did your skin problem begin?___________________________________

Are your present skin problems getting more pronounced?______________________

Do you have a history of keloid scarring?___________________________________

Do you have a history of: (check all that apply)

_____Heart disease _____Diabetes

_____Herpes sores _____Bleeding disorders

_____Bruising _____Dark spots after pregnancy

_____Skin injury _____Skin cancer, or suspicious moles

Do you have any skin related allergies? Yes No
*If yes, please specify:*____

Do you have any allergies to medication or Latex? Yes No
*If yes, please specify:*____

Have you had any allergic reactions to anesthesia? Yes No

Do you take any medication?

_____Aspirin _____Anti-coagulants (blood thinners)

_____Hormones/contraceptives _____Appetite depressant (diet pills)

_____Thyroid medication _____Insulin

_____Sedatives _____Tranquilizers

_____Cortisone _____Retinol/Retin-A

_____Other (please specify):____

Have you had a history of cold sores or fever blisters? Yes / No

If so, How often do you tend to break out?:_______________________________________

Please list all surgeries that you have had (include plastic surgery and wisdom teeth removal) with the date you had the surgery:____

____

____

I acknowledge that I have disclosed my complete medical history and the above is a complete and accurate representation of my medical and psychological status.

I, ______________________________________, represent to the physicians and staff that I am at least 18 years of age or, if not, am accompanied by a legal guardian. I hereby consent to and authorize a history examination by my doctor and such assistant or staff as may be assigned by him/her.

I understand that photography is a necessary part of planning and evaluating cosmetic procedures. I authorize the taking of photographs at the direction of my physician or physician delegate and under such conditions as may be approved by him/her. It is understood the use of photographs is for illustrating the medical procedure and demonstration of treatment outcomes. It is also understood that the use of the photographs will in no way reveal the patient's name.

Signature:____ Date:_________________________

Witness:____ Date:_________________________