Vein Treatment Institute

of Bucks County

David N. Brotman, M.D.

ADDITIONAL PATIENT MEDICAL HISTORY FOR LASER TREATMENTS

Name: _____ Date of Birth: _____

Medical History:

Do you have a history of seizures ? …… Yes No
Do you have problems with cold sores/Herpes ? …….. Yes No
Are you Pregnant or Lactating ? …….. Yes No
Have you been on Accutane in the past 6 months ? ……... Yes No
Any other medications that make you photo sensitive ? _____
List all medications you are currently taking (blood thinners, antibiotics, herbs, supplements, vitamins, aspirin etc.): _____

_____

Any Allergies to Medications ? _____

Skin Background:

Have you had prolonged sun exposure (or tanning bed) in the past 3 days? ……. Yes No
If so, are you currently sunburned ? ……... Yes No
Do you use tanning beds ? …….. Yes No
Are you using chemical tanning solutions ? ……... Yes No
Do you use sunscreen on a regular base ? …….. Yes No

When exposed to the sun without protection for approximately 1 hour, I : (Check <u>one</u>)

___ (I) Always burn, never tan
___ (II) Usually burn, tan less than average
___ (III) Sometimes mild burn, tan about average
___ (IV) Rarely burn, tan more than average
___ (V) Rarely burn, tan profusely
___ (VI) Never burn, deeply pigmented

Skin Type: (Circle one)

Caucasian Hispanic Mediterranean African American American Indian Asian Other

Check other services of interest:

_____ Laser Hair Removal (list different areas) _____
_____ Laser Vein Removal
_____ Non-ablative LaserFACIAL (wrinkle reduction, improved complexion)

I certify that the above medical history information is accurate and correct:

Patient Signature: _____ Date: _____