New Patient Intake Form
Aesthetic and Laser Treatments

MIDDLETOWN VEIN & AESTHETIC CENTER

57 S Main St Middletown, CT 06457 ***860-638-0050***

This form is to help us treat you better. Please keep us updated of any changes in your health or medications. Always feel free to ask us any questions that may arise. This form is confidential.

Please complete the following:

Name:_____ Date of Birth: ___ / ___ /___

Address:_____

City / State / Zip _____

Home Phone # _____ Cell Phone # _____

Email Address:_____

How did you hear about us? : _____

Which phone # may we use to contact you? _____

Can we leave a message at this number?: _____

May we speak with your spouse / significant other / family regarding your treatment? Yes / No
Name: _____

May we contact you via Email? □ Yes □ No Email address:_____

Please advise any additional requests for privacy below:

_____

_____

Print Client Name: _____

Signature of Client: _____ _____
(Client/Parent or Guardian if patient is under 18) Date

Please print name if you are the Parent/Guardian:_____

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Personal Profile and Medical History:

Females: Are you pregnant? ☐ Yes ☐ No Are you breastfeeding? ☐ Yes ☐ No

Medical History:

Please complete the following items and always inform of us any changes in your medical history and / or medications.

Medications (prescription and over the counter drugs, vitamins, herbs, and / or supplements):

_____

_____

***ALLERGIES** to any medications?* _____

_____

Symptoms: (please check all that apply)

- ☐ Acne
- ☐ Bleeding Disorders
- ☐ Burns/skin grafts
- ☐ Claustrophobia
- ☐ Seizures
- ☐ Shingles
- ☐ Skin Cancer
- ☐ Tattoos
- ☐ Thyroid Disease
- ☐ Vitiligo
- ☐ Permanent Makeup
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Hirsutism
- ☐ Hormone Replacement Rx
- ☐ Cold Sores
- ☐ Diabetes
- ☐ Eczema
- ☐ Endocrine Disorders
- ☐ Epidermolysis Bullosa
- ☐ Heart Disease
- ☐ Hemorrhoids
- ☐ HIV/AIDS
- ☐ Precocious Puberty
- ☐ Psoriasis
- ☐ Rosacea
- ☐ Implants
- ☐ Kaposi's Sarcoma
- ☐ Keloid Scars
- ☐ Lupus
- ☐ Polycystic Ovary Disease
- ☐ Port-Wine Stain
- ☐ Herpes
- ☐ Other:_____

Surgeries: _____

Please list any other pertinent medical information:_____

_____

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PERSONAL PROFILE & MEDICAL HISTORY – Continued:

1. Have you used Accutane in the last 6 months?	Yes	No
a. If yes, how recently?_____		
2. Are you currently using glycolic acid or Retin A?	Yes	No
3. What products are you currently usng on your skin?		
a. Describe:_____		
4. Do you have any active skin diseases or infections in the area to be treated?	Yes	No
5. Are you allergic to latex, lidocaine, or any lotions?	Yes	No
6. Have you had any permanent cosmetic tattooing to the area to be treated?	Yes	No
7. Do you have any metal or other implants? Where?_____	Yes	No
8. Have you had any previous laser treatment or other skin treatments to the area to be treated? Describe:_____	Yes	No
9. Are there any moles with hair in the area to be treated?	Yes	No
10. Do you have history of skin breakouts?	Yes	No
11. Do you have any scarring as a result from your breakouts/acne?	Yes	No
12. Have you been exposed to sun with the last 4 to 6 weeks?	Yes	No
a. If yes, approximate date of last exposure _____ / _____ / _____		
13. Do you use tanning beds? If yes, date of last use _____ / _____ / _____	Yes	No
14. Do you burn easily in moderate sunlight?	Yes	No
15. Do you blush when nervous?	Yes	No
16. Do you frequently experience flakiness, tightness or dryness?	Yes	No
17. Do you use sunscreen on a regular basis?	Yes	No
18. Have you waxed, used depilatories, bleaches or other chemicals?	Yes	No
19. How much water do you normally consume daily? _____		
20. Do you smoke?	Yes	No
21. Do you wear contact lenses?	Yes	No
22. Do you exercise?	Yes	No
23. Have you had microdermabrasion?	Yes	No
24. Have you had any chemical peels?	Yes	No
25. Have you had laser resurfacing?	Yes	No
26. Do you have wrinkle concerns?	Yes	No
27. Do you have scarring concerns?	Yes	No
28. Do you have sun damage concerns?	Yes	No
29. Do you have pigmentation concerns?	Yes	No
30. Do you have broken capillary concerns?	Yes	No

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What services are you most interested in?_____

_____

Name of family doctor:_____ Phone # _____

I confirm that the answers to the questionnaire are true and correct. I also confirm that the consultant has clarified any questions I did not understand.

Print Patient Name:_____

Signature:_____ Date: _____
(Parent or Guardian if patient is under 18)

Physician's Signature:_____

***I understand that payment for any cosmetic services or products is expected in full at the time of service.**

Signature:_____ Date: _____
(Parent or Guardian if patient is under 18)
