SOUTH FLORIDA VASCULAR ASSOCIATES
Leading Change in Vascular Care

Personal Profile and Health History

Name:_____ Home Phone:_____

Address:_____ Work Phone:_____

City/State/Zip: _____

Date of Birth: _____ Age:_____ Gender: M____F_____

Occupation: _____ Email address:_____

How did you hear about us?_____

What cosmetic/aesthetic procedures are you interested in?

_____

Please share any questions, concerns or comments:

_____

Females: Are you pregnant? ❑ Yes ❑ No Are you breastfeeding? ❑ Yes ❑ No
Are you planning pregnancy during the course of your treatment? ❑ Yes ❑ No

Your genetic background affects your skin and its response to the laser. Please specify your ethnic origin:
❑ African American ❑ Asian ❑ Caucasian ❑ Hispanic ❑ Mediterranean
❑ Middle Eastern ❑Native American ❑ Other _____

Please complete the following items of medical history. Please, always inform us of any change in your medical history and/or medications. Please list **all** medications including prescription and over the counter drugs, vitamins, herbs, supplements.

_____

Are you allergic to any medications? ❑ Yes ❑ No Please list medications and reactions.

_____

Medical History: Please check all that apply

- ☐ Acne
- ☐ Bleeding Disorders
- ☐ Burns/Skin Grafts
- ☐ Diabetes
- ☐ Endocrine Disorders
- ☐ Gold Therapy
- ☐ Heart Disease
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Hirsutism
- ☐ Hormone Replacement RX
- ☐ Implants
- ☐ Kaposi's Sarcoma
- ☐ Keloid Scars
- ☐ Lupus Erythematosus
- ☐ Permanent Makeup
- ☐ Precocious Puberty
- ☐ Psoriasis
- ☐ Seizures
- ☐ Shingles
- ☐ Skin Cancer
- ☐ Tattoos
- ☐ Thyroid Disease
- ☐ Vitiligo
- ☐ Other

☐ Surgery in the area to be treated? If "Yes", please explain _____

_____

William H. Julien, MD
5300 West Hillsboro Blvd Suite 107 Coconut Creek, FL 33073
T (954) 725-4141 F (954) 725-4318
www.SouthFloridaVascular.com

SOUTH FLORIDA VASCULAR ASSOCIATES
Leading Change in Vascular Care

Personal Profile and Health History

If the answer to any of the following questions is yes, please provide details in the space provided.

Are you currently being treated for any medical conditions?	Yes	No
Explain:_____		
Have you used Accutane in the last 6 months? How recently? _____	Yes	No
Do you have any active skin diseases or infection in the area to be treated?	Yes	No
Do you have any skin allergies?	Yes	No
Are you allergic to latex, lidocaine, or any lotions? Please circle any that apply	Yes	No
Are you currently using glycolic acid or Retin A? Please circle any that apply.	Yes	No
Have you had a chemical peel or facial within the last week?	Yes	No
What products are you currently using on your skin?		
Describe: _____		
Have you had any permanent cosmetic tattooing to the area to be treated?	Yes	No
Do you have any metal or other implants? Where? _____	Yes	No
Have you had any previous laser treatment or other skin treatment to the area		
to be treated? Describe: _____	Yes	No
Are there any moles with hair in the area to be treated?	Yes	No
Are you currently using or have used within the last six weeks a tanning bed or		
tanning cream? If yes, date of last use _____	Yes	No
Have you been exposed to the sun within the last four to six weeks?	Yes	No
If yes, approximate date of last exposure _____		

Name of your family doctor: _____ Phone No. _____

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.

Signature of Client: _____ Date: _____

Signature of Consultant: _____ Date: _____

Signature of Nurse: _____ Date: _____

Medical Director Review: _____ Date: _____

William H. Julien, MD
5300 West Hillsboro Blvd Suite 107 Coconut Creek, FL 33073
T (954) 725-4141 F (954) 725-4318
www.SouthFloridaVascular.com