ADVANCED VEIN & LASER CENTER
veinsbegone.com

NEW PATIENT INFORMATION FOR SCULPSURE TREATMENT

Patient Name: _____ **Patient ID:** _____

Date_____

Street Address:			Mobile Phone:
City:	State:	Zip:	Home Phone:
Email address:		D.O.B:	Age:
Emergency Contact:	Relationship:		Phone:
How did you hear about SculpSure at AVLC?			

GOALS

What body area(s) are you most interested in treating today?

_____

What are your expectations at the completion of treatment?

_____

WEIGHT LOSS HISTORY:

Do you currently have an exercise and nutrition plan? ◯ Yes) No

Has any weight loss method worked well for you in the past? For example, “On my own”, supplements, surgery, medications, low carb/high protein.

) Yes ◯ No

If Yes, please describe:

_____

Have you ever had a complication or bad experience from weight loss ◯ Yes) No

If Yes, please describe:

_____

SKIN HISTORY

Do you currently have a tan or plan to be exposed to the sun/artificial tanning in the next week? ◯

Yes ◯ No

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Are you currently taking medications that enhance photosensitivity? ◯ Yes) No

Do you have **ANY** current or chronic skin condition? ◯ Yes) No

Please disclose any history of skin photosensitivity, previous treatment with parental gold therapy, impaired or decreased skin sensation, scar/keloid formation, allergic dermatitis, psoriasis vitiligo, melasma, eczema, squamous cell carcinoma, melanoma, heat urticaria, ulcer formation, cellulitis, and any diseases affecting collagen including Ehlers-Danlos syndrome, Scleroderma, Rheumatoid Arthritis, or any other skin condition.

Please List:

_____

PAST MEDICAL HISTORY

Are you currently under the care of a physician? ◯ Yes ◯ No

If yes, for what condition(s)? :

_____

Do you have **ANY** current or chronic medical conditions? ◯ Yes ◯ No

Please disclose any history of abdominal hernia, diabetes, autoimmune disorders, immunosuppression, blood disorders, cancer, bacterial or viral infections, medical conditions that significantly compromise the healing response, or any other condition or illness.

Please List:

_____

_____

_____

PAST SURGICAL HISTORY

Please list any operations or procedures you have had, including cosmetic procedures:	**Date**	**List any complications**
1.		
2.		
3.		
4.		

Please list ALL prescription and over the counter medications, supplements, and vitamins you take, including dosage:

1. _____ 4. _____

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2.	5.
3.	6.

Are there any topical products (both medical and non-medical) that you use on your skin on a regular or daily basis? Please List:

_____

Please list ALL food, medication, environmental, and seasonal allergies you have	**What is your reaction?**
1.	
2.	
3.	
4.	
5.	

Females Only:

Is there any chance you could be pregnant today?	◯ Yes) No
Do you plan to become pregnant in the next 3 months?	◯ Yes) No
Are you currently breastfeeding?	◯ Yes) No

Staff Only:

Treatment 1

Treatment 2

Treatment 3