



5206 North Scottsdale Road
 Paradise Valley, AZ 85253
 480.948.5045
 www.vandykeasthetics.com

TELL US YOUR INTEREST/CONCERNS?

Circle all that apply

Voluma	Ultherapy	Volume Loss	Sweat
Fillers	Thermage Body	Wrinkles	Cellulite
Sculptra	CoolSculpting	Sun Damage	Stretch Marks
Botox/Dysport	Laser Hair Removal	Precancers	Body Contouring
Kybella	miraDry Sweat Reduction	Pigment	Skin Rejuvenation
Active Fx	Intense Pulse Light/IPL	Redness/Facial Veins	Skin Laxity
Fraxel	Skin Care	Pore Size	
Clear and Brilliant		Acne	

HISTORY OF...	YES	NO	WHEN WAS MOST RECENT TREATMENT/EPISODE?
Facial surgery			
Facial implants			
Skin cancers			
Skin pre-cancers			
Cold sore/fever blister			
Pacemaker			
Internal medical device			
Skin sensitivity to light			
Fillers			
Botox/Dysport			
Laser			
Chemical peel			

TELL US YOUR CURRENT SKIN CARE REGIMEN:

WITH EXTENDED SUN EXPOSURE DO YOU....				
Always burn	Burn then tan slowly	Occasionally burn, tan well	Rarely burn tan deeply	Never burn

Printed Name: _____ Date: _____



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Patient Medical History

AGE		HEIGHT		WEIGHT	
<i>Check all that apply</i>					
Blood transfusions	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	HIV	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Bleeding tendency	<input type="checkbox"/>
Dry eyes	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	Keloids	<input type="checkbox"/>
Lung disease	<input type="checkbox"/>	Heart attack	<input type="checkbox"/>	Abnormal scarring	<input type="checkbox"/>
TB	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	Difficulty healing	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	History of taking Accutane	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	Scleroderma	<input type="checkbox"/>	Problems with anesthesia	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	Depression	<input type="checkbox"/>	Heart burn	<input type="checkbox"/>
Irregular Heart Beat	<input type="checkbox"/>	Hepatitis B	<input type="checkbox"/>	Gum Disease	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	Hepatitis C	<input type="checkbox"/>	Cold Sensitivity	<input type="checkbox"/>
OTHER					

SURGERIES: YES/NO
 IF YES, LIST:

MEDICATIONS: YES/NO
 IF YES, LIST:

OVER THE COUNTER MEDICATIONS/VITAMINS/SUPPLEMENTS: YES/NO
 IF YES, LIST:

ALLERGIES: YES/NO
 IF YES, LIST:

SMOKE: YES/NO _____ PACKS PER DAY FOR _____ YEARS

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

Signature: _____

Printed Name: _____ Date: _____