LOVA

Lake Oswego Vein and Aesthetic

General Information

Full Name: _____Today's Date:_____

Date of Birth:_____Age:_____Sex:_____Weight:_____Height:_____

Address: _____

City,State:_____Zip Code:_____Occupation:_____

Phone:_____Email:_____

How did you hear about LOVA ?_____Preferred Method of Contact:_____

Patient Concerns

Varicose Veins	☐ Yes ☐ No	Acne	☐ Yes ☐ No
Spider Veins - Face	☐ Yes ☐ No	Unwanted Tattoos	☐ Yes ☐ No
Spider Veins - Body	☐ Yes ☐ No	Skin Texture/Scarring	☐ Yes ☐ No
Lines/Wrinkles	☐ Yes ☐ No	Stubburn Fat Deposits	☐ Yes ☐ No
Skin Laxity	☐ Yes ☐ No	Stretch Marks	☐ Yes ☐ No
Brown Spots/Hyperpigmentation	☐ Yes ☐ No	Hair Removal	☐ Yes ☐ No
Rosacea/Skin Redness	☐ Yes ☐ No	Hair Restoration	☐ Yes ☐ No

Are you interested in a specific procedure/service?_____

What skincare products are you currently using?_____

_____

Aesthetics History

Please indicate which treatments and products you have had and used:

Botox/Xeomin/Dysport	☐ Yes ☐ No	Recent sun exposure/tanning bed/Self-tanning products	☐ Yes ☐ No
Dermal Fillers	☐ Yes ☐ No		
Sclerotherapy	☐ Yes ☐ No	Accutane	☐ Yes ☐ No
PDO Threads	☐ Yes ☐ No	PRP	☐ Yes ☐ No
Laser/IPL	☐ Yes ☐ No	Body Contouring	☐ Yes ☐ No
Retinol/Retin-A	☐ Yes ☐ No	Tattoos/Permanent Makeup	☐ Yes ☐ No
Hydroquinone/Tretinoin	☐ Yes ☐ No	Gold Therapy	☐ Yes ☐ No

When was your last facial?_____Date:_____

Have you received previous surgery (medical, cosmetic, plastic) ☐ Yes ☐ No If yes, please list below :

Surgery:_____Date:_____

Surgery:_____Date:_____

Surgery:_____Date:_____

Surgery:_____Date:_____

Any adverse reaction to any of the above? ☐ Yes ☐ No _____

Were you pleased with your cosmetic or plastic surgery results? ☐ Yes ☐ No _____

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Medical History

Diabetes	☐ Yes ☐ No	Epilepsy/Seizures	☐ Yes ☐ No
Cold Sores	☐ Yes ☐ No	Eczema/Psoriasis/Melasma	☐ Yes ☐ No
Keloids/Hypertrophic Scarring	☐ Yes ☐ No	Asthma/COPD	☐ Yes ☐ No
Vitiligo	☐ Yes ☐ No	Cancer: Type:_____	☐ Yes ☐ No
Headaches/Migraines	☐ Yes ☐ No	Active Implants (cosmetic & medical)	☐ Yes ☐ No
Anxiety/Depression	☐ Yes ☐ No	Bleeding/Clotting Disorder	☐ Yes ☐ No
Currently Pregnant or Lactating	☐ Yes ☐ No	Neurological Disorder:_____	☐ Yes ☐ No
Hernia:_____	☐ Yes ☐ No	Autoimmune Disease:_____	☐ Yes ☐ No
Hypertension	☐ Yes ☐ No	Hepatitis:_____	☐ Yes ☐ No
Heart Disease	☐ Yes ☐ No	Postmenopausal	☐ Yes ☐ No
Stroke	☐ Yes ☐ No	Thyroid: Low or High_____	☐ Yes ☐ No
HIV/AIDS	☐ Yes ☐ No	Poor Circulation	☐ Yes ☐ No
Kidney Disease	☐ Yes ☐ No	MRSA	☐ Yes ☐ No

List any Chronic Illnesses:_____

List any Drug Allergies:_____

Other Allergies we should be aware of:_____

Do you require antibiotics prior to dental treatments? ☐ Yes ☐ No If yes, what antibiotic?_____

List all **medications and/or supplement** below. Please include prescription and non-prescription medication. If you are not taking any medications or supplements please **initial here**: _____

Medication/Supplement	Reason for Taking	Dose	Frequency	Last Taken

Ethnicity/Ethnic Background (Important for Laser Treatments):_____

In the last 12 months, have you experienced: ☐ Weight Gain? ☐ Weight Loss? Amount:_____lbs. ☐ N/A

Do you experience complications with: ☐ Healing ☐ Bleeding ☐ Bruising

Do you currently smoke cigarettes? ☐ Yes ☐ No If you quit smoking cigarettes, how long did you smoke ?_____

Do you drink alcohol? ☐ Yes ☐ No If yes, how often and how much?_____

New Client Agreement

I hereby certify that the foregoing information is accurate and complete and that I will notify Lake Oswego Vein and Aesthetic of any changes. I will not hold the doctor, or any other staff member, responsible for any errors or omissions that I have made in completion of this form.

Print Name:_____ Patient Signature:_____