**THE COSMETIC VEIN & LASER CENTER**
**52 South Union Road, Suite 203**
**Williamsville, NY 14221**
**716-632-5200 (telephone)**
**716-632-5201 (fax)**

# Medical Intake Sheet

**Name** _____ **Date** _____

**Date of Birth** _____

**What are your concerns today?**

1. _____
2. _____
3. _____

**Current Medications**

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**Diagnosis**

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| **Drug Allergies** | **Reaction** |
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**Page Two – Medical Intake Sheet**

**Alternative medications/vitamins**

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**Have you ever had any of the following?**

1. Reaction or allergies to local anesthetics such as those used by the dentist? If yes, please explain_____
2. Bleeding disorders, frequent nosebleeds, easy bruising or bleeding problems? If yes, please explain_____
3. Have you ever fainted? If yes, please explain? _____
4. Do cuts on your skin heal with normal scars? If no, please explain _____ _____
5. Are you allergic or have a "bad reaction" to any substances applied to your skin? If yes, please explain_____

**Previous hospital admissions/surgical history**

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**Family history of melanoma?** ____ If so, which relative? _____

**Skin Disease History (please check all that apply)**

☐ History of melanoma (if so when, where, location on body, treatment type) _____

_____

☐ Basal cell cancer

☐ Squamous cell cancer

☐ Actinic keratosis

☐ Precancerous moles

**Other skin disease you have had _____**
**Do you wear sunscreen? ___ Yes ___No If yes, what SPF? _____**

**Do you use or have you used a tanning bed? ___Yes ___ No**

**If yes, when did you stop? _____**

**Would you like a skin check today for cancer screening? ___**