

VeinTherapies
Laser Skin and Vein Solutions
W. Clark Beckett, M.D., F.A.C.S.

3770 7th Terrace, Suite 102 * Vero Beach, Florida 32960 * 772.567.6602 * Fax 772.567.7754

DATE: _____

PATIENT EMAIL: _____
(to receive emails on our latest laser information)

How did you hear about us? (circle one) Friend Press Journal Physician VB Magazine

Other _____

SECTION A: PATIENT INFORMATION

NAME:

LAST _____ FIRST _____ INITIAL _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE _____ CELL PHONE _____ DATE OF

BIRTH _____

SECONDARY ADDRESS _____

CITY _____ ST _____ ZIP _____ PHONE _____

PATIENT SOCIAL SECURITY # _____ MARITAL STATUS _____

PERSON RESPONSIBLE FOR BILL _____ REFERRED BY _____

EMPLOYER _____ OCCUPATION _____

STREET ADDRESS _____ CITY _____ ST _____ ZIP _____

PHONE # _____

SECTION B: SPOUSE INFORMATION

NAME _____ DATE OF BIRTH _____ SOC.SEC.# _____

EMPLOYER _____ OCCUPATION _____

STREET ADDRESS _____ CITY _____ ST _____ ZIP _____

HOME PHONE _____ CELL PHONE _____

SECTION C: IN CASE OF EMERGENCY, PLEASE NOTIFY:

NAME _____ RELATIONSHIP _____ PHONE _____

RELATIVE _____ RELATIONSHIP _____ PHONE _____

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Medical History
Botox™

Name _____ Date _____

DOB _____ Age _____

Primary Physician's Name and Phone Number _____

Please list all medications you are currently taking: _____

List all vitamin supplements you are on: _____

List all Allergies: _____

Circle any of the following illnesses you have or have ever had in the past:

Myesthenia Gravis Hepatitis Eye Disease Autoimmune Disease Vision Problems

Numbness Muscle Weakness Multiple Sclerosis ALS

Parkinson's Disease Neurological Disorders Lambert-Eaton Syndrome

List and/or explain other medical conditions not listed above:

Previous hospitalizations/operations: _____

Female: Are you pregnant, trying to get pregnant or lactating (nursing)? _____

Have you: Had plastic surgery or other surgery to your face/neck areas? When? _____

Had Botox injections before? _____ Last treatment? _____ What areas? _____

Happy with the previous Botox treatments? Explain _____

Ever had eyelid/eyebrow drooping after Botox? Explain _____

Have you been told you have 'sleep eyes' or 'bedroom eyes'? Explain _____

Do you show a lot of upper eye lid when eyes are open? Explain _____

Do your eyelids feel extra heavy when you don't get enough sleep? _____

Do your eyelids droop without sleep? _____

I understand the information on this form is essential to determine my medical and cosmetic needs and the provision of treatment. I understand that if any changes occur in my medical history/health I will report it to VeinTherapies as soon as possible. I have read and understand the above medical history questionnaire. I acknowledge that all answers have been recorded truthfully and will not hold any staff member responsible for any errors or omissions that I have made in the completion of this form.

Patient signature _____ Date: _____