

# lavé md

LASER AND VEIN ESTHETICS

## History and Physical

DATE \_\_\_\_\_

NAME \_\_\_\_\_ SEX: M \_\_\_\_\_ F \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

### CURRENT CONDITION RELATED TO TODAY'S APPOINTMENT:

\_\_\_\_\_

ASSOCIATED SYMPTOMS: \_\_\_\_\_

WHAT MEDICAL PROBLEMS HAVE YOU HAD IN THE PAST, OTHER THAN WHAT YOU ARE SEEING THE DOCTOR TODAY? THESE MAY BE ACTIVE OR NOT BOTHERING YOU NOW; SOME EXAMPLES: CANCER, COLON PROBLEMS, PNEUMONIA, BRONCHITIS, DEPRESSION, MIGRAINES, etc. \_\_\_\_\_

\_\_\_\_\_

PAST SURGICAL HISTORY: \_\_\_\_\_

NAME OF PHYSICIAN WHO REFERRED YOU \_\_\_\_\_

### HAVE YOU EVER HAD OR ARE YOU NOW EXPERIENCING ANY OF THE FOLLOWING CONDITIONS?

(PLEASE CHECK IF YES)

HIGH BLOOD PRESSURE \_\_\_\_\_

HEPATITIS \_\_\_\_\_

DIABETES \_\_\_\_\_

ULCER DISEASE \_\_\_\_\_

HEART PROBLEMS \_\_\_\_\_

VASCULAR DISEASE \_\_\_\_\_

CANCER \_\_\_\_\_

BLOOD CLOTS \_\_\_\_\_

HIV \_\_\_\_\_

ARE YOU TAKING ANY MEDICATIONS NOW? YES \_\_\_\_\_ NO \_\_\_\_\_ IF YES, PLEASE LIST THEM

\_\_\_\_\_

\_\_\_\_\_

DO YOU HAVE ANY ALLERGIES TO MEDICINES? YES \_\_\_\_\_ NO \_\_\_\_\_ IF YES, PLEASE LIST THEM:

\_\_\_\_\_

\_\_\_\_\_

### PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR SOCIAL AND FAMILY HISTORY:

DO YOU SMOKE? YES \_\_\_\_\_ NO \_\_\_\_\_ HOW MANY PACKS A DAY? \_\_\_\_\_

DO YOU DRINK? YES \_\_\_\_\_ NO \_\_\_\_\_ HOW MUCH OR HOW FREQUENT? \_\_\_\_\_

HAS ANYONE IN YOUR FAMILY (MOTHER, FATHER, BROTHERS, SISTERS, GRANDMOTHERS, GRANDFATHERS) EVER HAD ANY OF THE FOLLOWING CONDITIONS? PUT A CHECK NEXT TO EACH.

HIGH BLOOD PRESSURE \_\_\_\_\_

VARICOSE VEINS \_\_\_\_\_

DIABETES \_\_\_\_\_

CANCER \_\_\_\_\_

HEART PROBLEMS \_\_\_\_\_

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## LASER AND VEIN ESTHETICS

### HIPPA

#### PATIENT AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH CARE INFORMATION

Patient's Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security: \_\_\_\_\_

Effective April 14, 2003, the federal government set a law in place to protect you and the release of your medical information whether it be in written or oral form. Our office is permitted by law not to release protected health information outside of treatment, payment, and healthcare operations without your written consent.

Please list the people (including family members) or companies in which you wish the office of David Vanderpool, M.D. to release your medical records.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_

This request and authorization applies to:

Healthcare information relating to the following treatment, condition, or dates of treatment: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ All Healthcare information

I hereby authorize the office of David Vanderpool M.D. to release my protected health information to the above people listed. I understand I have the right go revoke this consent at anytime in writing. I am also aware that this consent is binding and will expire two years from the date of signature.

\_\_\_\_\_  
Patient's signature

\_\_\_\_\_  
Date of Signature

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## SPA PATIENT INFORMATION

Name: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M / F

Marital Status: Married \_\_ Single \_\_ Divorced \_\_ Widowed \_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home: (\_\_\_\_)-\_\_\_\_\_ Work: (\_\_\_\_)-\_\_\_\_\_ Cell: (\_\_\_\_)-\_\_\_\_\_

Social Security: \_\_\_\_/\_\_\_\_/\_\_\_\_ E-mail: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ (\_\_\_\_)-\_\_\_\_\_

Allergies: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Please put a check mark next to the procedures about which you would like to receive more information:

- |  |   |
|--|---|
| <input type="checkbox"/> Enhanced Skin Rejuvenation  | <input type="checkbox"/> Brown Spots                        |
| <input type="checkbox"/> Wrinkles                    | <input type="checkbox"/> Sun Damage                         |
| <input type="checkbox"/> Broken Capillaries          | <input type="checkbox"/> Spider Veins/Leg Veins             |
| <input type="checkbox"/> Hair Removal                | <input type="checkbox"/> Skin Toning or Pore size Reduction |
| <input type="checkbox"/> Facial Redness              | <input type="checkbox"/> Red Birthmark Removal              |
| <input type="checkbox"/> Shaving Bumps/ Ingrown Hair | <input type="checkbox"/> Cellulite                          |

**Please put a check mark next to a past or current condition:**

- |   |   |
|---|---|
| <input type="checkbox"/> Lupus or other auto-immune deficiency (A)    | <input type="checkbox"/> Herpes simplex or fever blisters (A)                             |
| <input type="checkbox"/> Pregnant (A)                                 | <input type="checkbox"/> Diabetes (A)   |
| <input type="checkbox"/> Bleeding Abnormalities                       | <input type="checkbox"/> Epilepsy (A)   |
| <input type="checkbox"/> Treatment with Accutane in last 6 months (A) | <input type="checkbox"/> Scars that turn white or brown (A)                               |
| <input type="checkbox"/> Keloid or very thick scarring (A)            | <input type="checkbox"/> HIV (A)  |
| <input type="checkbox"/> Psoriasis or Vitiligo (A)                    | <input type="checkbox"/> Hepatitis (A)  |
| <input type="checkbox"/> Pulmonary embolism/blood clot (V)            | <input type="checkbox"/> Waxing/Plucking/Electrolysis in last 4 weeks (HR)                |
| <input type="checkbox"/> Leg Ulcer or Phlebitis (V)                   | <input type="checkbox"/> Hirsutism (HR)   |
| <input type="checkbox"/> Rheumatoid Arthritis                         | <input type="checkbox"/> Transplant Anti Rejection Drugs (HR)                             |
| <input type="checkbox"/> "Gold Therapy" (A)                           | <input type="checkbox"/> Retin A and Glycolic Acid (A)                                    |
|   | <input type="checkbox"/> Chemical Peels, Dermabrasion, Laser Resurfacing or Face Lift (A) |

**Please list any medications or herbal supplements that you are currently taking:** \_\_\_\_\_

\_\_\_\_\_

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## PATIENT INTEREST

Today's Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

DOB: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Has there been a change in your insurance?  YES  NO

Please put a check mark next to the procedures about which you would like to receive more information:

- |   |   |
|---|---|
| <input type="checkbox"/> BOTOX <sup>®</sup> Cosmetic            | <input type="checkbox"/> Skin Care Advice               |
| <input type="checkbox"/> Facial Fillers                         | <input type="checkbox"/> Skin Care Products             |
| <input type="checkbox"/> Collagen Stimulation                   | <input type="checkbox"/> Skin exfoliation               |
| <input type="checkbox"/> Body Contouring (Thermage)             | <input type="checkbox"/> Make up                        |
| <input type="checkbox"/> Fine Lines                             | <input type="checkbox"/> Sunscreen Advice               |
| <input type="checkbox"/> Deep Lines and Wrinkles                | <input type="checkbox"/> Facials                        |
| <input type="checkbox"/> Age Spots                              | <input type="checkbox"/> Eye Treatments                 |
| <input type="checkbox"/> Brown Spots / Sun Damage               | <input type="checkbox"/> Dry Skin                       |
| <input type="checkbox"/> Liver Spots / Sun Spots                | <input type="checkbox"/> Oily Skin                      |
| <input type="checkbox"/> Birthmarks                             | <input type="checkbox"/> Combination Skin               |
| <input type="checkbox"/> Melasma / Pregnancy Mask               | <input type="checkbox"/> Laser Treatments               |
| <input type="checkbox"/> Rosacea / Facial Redness               | <input type="checkbox"/> Laser Resurfacing              |
| <input type="checkbox"/> Facial veins / Broken Capillaries      | <input type="checkbox"/> Tattoo removal                 |
| <input type="checkbox"/> Micro-Dermabrasion                     | <input type="checkbox"/> Removing Leg Veins             |
| <input type="checkbox"/> Chemical Peels                         | <input type="checkbox"/> Spider Vein Treatments         |
| <input type="checkbox"/> Sagging / lax skin                     | <input type="checkbox"/> Laser Hair Removal             |
| <input type="checkbox"/> Skin Rejuvenation                      | <input type="checkbox"/> Massage Therapy                |
| <input type="checkbox"/> Photo aged skin                        | <input type="checkbox"/> Triactive/ Cellulite Treatment |
| <input type="checkbox"/> Pore appearance                        | <input type="checkbox"/> Ingrown Hair / Shaving Bumps   |
| <input type="checkbox"/> Skin tone and texture                  | <input type="checkbox"/> Laser Hair Removal             |
| <input type="checkbox"/> Avage <sup>™</sup> , Retin-A or Renova | <input type="checkbox"/> Waxing                         |
| <input type="checkbox"/> Acne                                   |   |
| <input type="checkbox"/> Acne Scars                             |   |

Other, please specify \_\_\_\_\_

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5409 Maryland Way, Suite 119  
Brentwood, TN 37027

We are located at the southeast corner of Granny White Pike and Maryland Way in the Maryland Farms Office Park of Brentwood. Our office is on the first floor of the Gateway Building, which sits directly behind Wachovia Bank. Entry to the parking lot for our building is available from either Granny White Pike or Maryland Way.

## **From I-65 North or South**

Exit at Old Hickory Blvd/Brentwood (exit 74-B)

Proceed approximately 2 miles West on Old Hickory Blvd. To Granny White Pike

Turn Left onto Granny White Pike and proceed one block (0.2 mile) to the intersection of Granny White Pike and Maryland Way. Turn left onto Maryland Way at the light. Wachovia Bank will be on your right. Just past the bank turn right into the Gateway Building parking lot. We are on the first floor, in Suite 119.

## **From Clarksville**

Take I-24 East to I-65 South and follow the above directions from I-65 South.

## **From I-24 West (From Smyrna, Murfreesboro, Chattanooga)**

Exit at Bell Road (exit 59)

Turn Left onto Bell Road (it will eventually become Old Hickory Blvd.) and proceed West for approximately 9.4 miles to the intersection of Old Hickory Blvd. and Granny White Pike in Brentwood.

Turn Left onto Granny White Pike and proceed one block (0.2 mile) to the intersection of Granny White Pike and Maryland Way. Turn Left, and just past the Wachovia Bank, turn Right into the Gateway Building parking lot. We are on the first floor, in Suite 119.

## **From I-40 East (From Dickson, Jackson, Memphis)**

Exit at US Hwy 70 South (exit 196)

Turn Right onto US Hwy 70 South and proceed northeast for approximately 2 miles.

Turn Right onto Old Hickory Blvd. And proceed East for approximately 1 mile.

Turn Left onto TN Hwy 100 and proceed north for approximately 0.6 mile.

Turn Right onto Old Hickory Blvd.(also TN 254) and travel approximately 5.4 miles to Granny White Pike.

Turn Right onto Granny White Pike and proceed one block (0.2 mile) to the intersection of Granny White Pike and Maryland Way. Turn Left, and just past the Wachovia Bank, turn Right into the Gateway Building parking lot. We are on the first floor, in Suite 119.