

# 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

### Vein Questionnaire

Name: \_\_\_\_\_

Please circle all that apply:

1. Do you take any of the following on a regular basis?  
Oral contraceptives    Premarin    Aspirin    Steroids    Digoxin
2. Are you allergic to:    Iodine    Local anesthetics (Xylocaine)    Tape
3. Do you have a family history of varicose veins or spider veins?    Yes    No  
If yes, please list the relatives who have them: \_\_\_\_\_
4. How many years have you had varicose or spider veins? \_\_\_\_\_
5. Did you first notice these veins: after an accident/trauma    before pregnancy  
After or during pregnancy    after taking hormones or oral contraceptives
6. Are you required to be on your feet for long periods of time?    Yes    No
7. Are you developing new veins?    YES    NO
8. Do you bruise easily?    Yes    No
9. Have you had any previous bypass surgery?    Yes    No
10. Do you have:    excessive bleeding    bleeding disorder    dizziness  
transient vision loss    transient weakness of limbs
11. Do you now have or have you had:  
unsightly veins    right    left  
Aches or pains    right    left  
Heaviness or tired legs    right    left  
Ankle edema or swelling    right    left  
Itching    right    left  
Night cramps    right    left  
Bleeding from veins    right    left  
Discoloration of legs    right    left  
Dermatitis (eczema)    right    left  
Ulceration    right    left
12. Do you have a previous history of:    Superficial phlebitis    right    left  
Deep thrombophlebitis    right    left  
Pulmonary emboli    right    left
13. Have you had treatments of:  
Compression stockings    right    left  
Length of time worn    \_\_\_\_\_  
Compression grade (mmHg)    15-20    20-30  
30-40    40-50  
Ligation    right    left  
Vein stripping    right    left  
Local excision    right    left  
Cautery    right    left  
Sclerotherapy    right    left
14. Do you have leg pains while walking in the:    foot    right    left  
Calf    right    left  
Thigh    right    left  
Buttock    right    left
15. Do you have leg pains while resting in the:    foot    right    left  
Calf    right    left

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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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LASER AND VEIN ESTHETICS

## PATIENT INFORMATION

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

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle: \_\_\_\_\_

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

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

E-Mail Address \_\_\_\_\_

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

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

Marital Status:  Married  Single  Divorced  Widowed

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

My Insurance is Covered Through:  Employer  Self  Spouse  Other

IF YOUR INSURANCE COVERAGE IS UNDER ANOTHER PERSON'S PLAN, PLEASE COMPLETE THE FOLLOWING:

Name of insured \_\_\_\_\_

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

### INSURANCE AUTHORIZATION:

I hereby authorize my insurance benefits to be paid directly to David Vanderpool, M.D. I realize I am responsible for any fees not covered by my insurance policies. I also authorize the release of pertinent medical information to my insurance carriers.

Patient Signature \_\_\_\_\_ Date: \_\_\_\_\_

### Patient Rights

Effective April 14, 2003: The Federal Government set a law in place to protect you and the release of your medical information. We, at Dr. Vanderpool's Office, promise to do our part in upholding this law. Our office is permitted by federal laws to make uses and disclosures of your health information for purposes of treatment, payment, and healthcare operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examinations, test results, diagnoses, treatment, and applying for future care of treatment. It also includes billing documents for those services.

A Copy of the Federal Privacy Law is available to you at your request

Yes, I would like a copy of the Federal Privacy Law  No, I would not like a copy of the Federal Privacy Law  
I have read about information regarding the Federal Privacy Law and understand my rights as a patient at this office.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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LASER AND VEIN ESTHETICS

## 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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LASER AND VEIN ESTHETICS

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.