Albuquerque Vein & Laser Institute
Aesthetic Personal Health History

Please complete this form to the best of your ability. If you have any questions, please talk to the nurse when you are called to the back.

Last Name:_____First Name:_____ Middle Name:_____
Date Of Birth: (Month/Day/Year) _____ How did you hear about our clinic: _____
Address:_____
Home Phone:_____ Cell Phone:_____ E-mail: _____

For your safety, we request that you provide the contact information of a relative, friend, or guardian whom you give consent to the staff at Albuquerque Vein and Laser Institute to contact in the case of an emergency or in a situation where we are attempting to reach you urgently, but we are not able to get in contact with you. We may divulge limited personal medical information to this contact person should we feel that it is necessary.

Name:_____ Relation to you:_____
Phone Number:_____Alternate Phone Number:_____

Do you have any allergies? **Yes**___ **No**___
If YES, what are you allergic to?

_____

Are you taking any **PRESCRIBED MEDICATIONS**, herbal products, and/or non-prescription drugs? **Yes**___ **No**___
If YES, please list all:

_____

_____

_____

Past surgical procedures including date:_____

_____

_____

Have you or any member of your family had any problems with local/topical anesthesia? **Yes**___ **No**___ If YES, please describe:

_____

Have you had any problems with dental anesthetic? **Yes**___ **No**____
If YES, please describe: _____

Height:_____ Weight:_____

Have you ever had any of the following:

	Yes	No		Yes	No
Chemical peels/Dermabrasion			Botox/Fillers		
Laser skin treatment			Face Lift		
Other cosmetic procedures			Liposuction		

If YES, please specify date of treatment:_____

_____

_____

Do you currently have or have you ever experienced any of the following medical problems/treatments?:

	Yes	No		Yes	No
Pacemaker/Defib			HIV/AIDS		
Heart Attack			Herpes simplex/fever blisters		
Other heart disease			Cancer		
High blood pressure			Skin cancer		
Bleed clots			Rheumatologic Disease		
Bleeding disorders			Diabetes Type I/Type II		
Stroke			Lupus/Auto-immune disease		
Blood thinning meds			Scleroderma		
Asthma/Lung disease			Keloids/Thick scarring		
Sleep apnea			Organ transplant		
Epilepsy/Seizures			Psoriasis		
Fainting spells			Vitiligo		
Kidney disease			Anxiety disorder		
Hepatitis/Liver disease			Muscle disorder		
			Treatment with Accutane, Epuris or Isotretinoin in past 6 months?		

Please provide details of the above and list any other medical conditions or impairments:

_____

_____

Please be aware that for safety reasons, please do not bring your children, family members (unless absolutely necessary), or friends into the LASER treatment rooms. Should you need to bring your children to the clinic for your laser appointment without another responsible person with them, please be aware they will need to remain in the waiting area and that Albuquerque Vein and Laser Institute and staff shall not be responsible for them. We sincerely thank you for your attention and understanding to the above.

Patient Signature: _____ Date: _____

I certify that I have reviewed the patient's medical history.

Practitioner Signature: _____ Date: _____

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This notice applies to all of the records of your care generated by the practice, whether made by the practice or an associated facility. This notice of Privacy Practices is being provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA).

HOW WE MAY USE AND DISCLOSE YOUR MEDICAL INFORMATION
We will routinely use your medical information inside our office for these purposes without any special permission:

Treatment - Our practice may use and disclose your medical information to treat you.
Payment - We may use and disclose your medical information in order to bill and collect payment for services.
Health care operations - Our practice may use and disclose your medical information to operate our business.

In addition, we may use or disclose your medical information for the following reasons:

Appointment reminders- Our practice may use and disclose your medical information to contact you and remind you of an appointment.
Treatment options and health-related benefits - To inform you of potential treatment options or services that may be of interest to you.
Disclosures required by law - Our practice may use and disclose your medical information when we are required to do so by federal, state, or local law.
Health oversight activities - Oversight activities can include investigations, inspections, audits, surveys, licensure and disciplinary actions, civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.
Lawsuits and similar proceedings - If you are involved in a lawsuit or similar proceeding, we may use and disclose your medical information in response to a court or administrative order or to defend the office.
Serious threat to health/safety - We may use or disclose your medical information when it is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public.
Involvement in individual's care - We may disclose your medical information about you to a family member, close personal friend or other person identified by you if directly relevant to that person's involvement with your care or payment related to your health care.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

Your rights include but are not limited to the following:
- Confidential communications. You have the right to request that we communicate with you in certain ways. Albuquerque Vein & Laser Institute will accommodate reasonable requests.
- Inspection and copies of records. With limited exceptions, you may inspect and obtain a copy of your protected health information that is contained in a designated record set for as long as we maintain the protected health information. This request must be made in writing and you may be charged a fee for the costs of copying, mailing, and other costs incurred by us in complying with your request.
- The right to request amendments to your information. You may request an amendment of protected health information about you as long as we maintain this information. Requests must be made in writing and must be directed to the office manager.
- Disclosures. You have the right to a detailed list of all disclosures our practice has made of your medical records.
- Paper copy or complaints. You have the right to a paper copy of this notice and the right to file a complaint with the office manager if you feel that your privacy rights have been violated at any time.

I have received a copy of Albuquerque Vein & Laser Institute's Notice of Privacy Practices.

Signature _____ Date _____