Name: ______________________________ Date of birth: ______________

FEMALE PATIENT QUESTIONNAIRE & HISTORY

Name: ______________________________ Date: ______________

Date of birth: __________ Age: ____ Weight: ______ Occupation: ______________

Home address: ____

City: ______________ State: ______________ Zip: __________

Home phone: __________ Cell phone: __________ Work: __________

Preferred contact number: ______________________________

May we send messages via text regarding appts to your cell? ☐ Yes ☐ No

Email address: ______________________ May we contact you via email? ☐ Yes ☐ No

In case of emergency contact: ______________ Relationship: ______________

Home phone: __________ Cell phone: __________ Work: __________

Primary care physician's name: ______________________ Phone: __________

Address: ____
Address / City / State / Zip

Marital status (check one): ☐ Married ☐ Divorced ☐ Widow ☐ Living with partner ☐ Single

In the event we cannot contact you by the means you have provided above, we would like to know if we have permission to speak to your spouse or significant other about your treatment. By giving the information below you are giving us permission to speak with your spouse or significant other about your treatment.

Name: ______________________ Relationship: ______________

Home phone: __________ Cell phone: __________ Work: __________

Social:

☐ I am sexually active. OR ☐ I want to be sexually active. ☐ I do not want to be sexually active.

☐ I have completed my family. OR ☐ I have NOT completed my family.

☐ My sex life has suffered. OR ☐ I have not been able to have an orgasm or it is very difficult.

Habits:

☐ I smoke cigarettes or cigars_____per day. ☐ I use e-cigarettes_____a day. ☐ I use caffeine_____a day.

☐ I drink alcoholic beverages_____per week. ☐ I drink more than 10 alcoholic beverages a week.

Your Logo

Name: ______________________________ Date of birth: ______________

FEMALE PATIENT QUESTIONNAIRE & HISTORY CONTINUED

Drug allergies

Drug allergies: ______________________ If yes, please explain: ______________

Have you ever had any issues with local anesthesia? ☐ Yes ☐ No Do you have a latex allergy? ☐ Yes ☐ No

Medications currently taking: ______________________________

Current hormone replacement? ☐ Yes ☐ No If yes, what? ______________________

Past hormone replacement therapy: ______________________________

Family history:

☐ Heart disease ☐ Diabetes ☐ Osteoporosis ☐ Alzheimer's/dementia ☐ Breast cancer ☐ Other ______

Pertinent medical/surgical history:

- ☐ Breast cancer
- ☐ Uterine cancer
- ☐ Ovarian cancer
- ☐ Polycystic ovaries/PCOS
- ☐ Acne
- ☐ Excess facial/body hair
- ☐ Infertility
- ☐ Endometriosis
- ☐ Epilepsy or seizures
- ☐ Fibrocystic breast or breast pain
- ☐ Uterine fibroids
- ☐ Irregular or heavy periods
- ☐ Menstrual migraines
- ☐ Hysterectomy with removal of ovaries
- ☐ Partial hysterectomy (uterus only)
- ☐ Ophorectomy removal of ovaries only

Birth control method:

- ☐ Menopause
- ☐ Hysterectomy
- ☐ Tubal ligation
- ☐ Birth control pills
- ☐ Vasectomy
- ☐ IUD
- ☐ Infertility
- ☐ Other ______________

Name: ______________________ Date of birth: ______________

FEMALE PATIENT QUESTIONNAIRE & HISTORY CONTINUED

Medical history:

- ☐ High blood pressure or hypertension
- ☐ Heart disease
- ☐ Atrial fibrillation or other arrhythmia
- ☐ Blood clot and/or a pulmonary embolism
- ☐ Depression/anxiety
- ☐ Chronic liver disease (hepatitis, fatty liver, cirrhosis)
- ☐ Arthritis
- ☐ Hair thinning
- ☐ Sleep apnea
- ☐ High cholesterol
- ☐ Stroke and/or heart attack
- ☐ HIV or any type of hepatitis
- ☐ Hemochromatosis
- ☐ Psychiatric disorder
- ☐ Thyroid disease
- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Lupus or other autoimmune disease
- ☐ Other ______________________

Medical History & Questionnaire

Name:________________________________ Age:___________ Date of Birth:__/__/__ Gender: M F

Address:______________________________ City:______________ State:_________ Zip:___________

Telephone: Home:______________________ Work:___________________ Cell:__________________

E-Mail:_____________________________________ How Did You Hear About Us:__________________

In Case of Emergency, Who May We Contact?__________________________ Phone:______________

Pharmacy: ____

Medical History

Have you ever had (please check all that apply):

__ Heart Disease/Heart Attack
__ Diabetes
__ History of Cancer
__ Chronic Skin Conditions
__ Lupus
__ HIV or AIDS
__ Hypertension
__ Epilepsy
__ Endocrine/Hormone Disorder
__ Heart Pacemaker or Defibrillator
__ Hepatitis
__ Planning/Current or Recent Pregnancy

List any active medical problems you have: ____

List any medications you currently take: ____

List any medication allergies you have: ____

Are you allergic to any numbing agents? _________ Are you allergic to latex? __________ Smoke? _________________

Surgical History

List any operations you have had with the year:

1. ________________________________ 3. ___________________________ 5. ____________________________
2. ________________________________ 4. ___________________________ 6. ____________________________

Dermatologic History

Have you ever had (please check all that apply):

__ Varicose or Spider Veins
__ Self Tanner
__ Laser Skin Resurfacing
__ Photosensitivity
__ Herpes Simplex or Cold Sores
__ Chemical Peel
__ Keloid or Hypertrophic Scar
__ Accutane use for Acne
__ Botox®,Dysport®, or Xeomin®Inj.
__ Pigmentation Disorder
__ Antibiotics use Regularly
__ Inj. Of Collagen or other Dermal fillers
__ Recent Waxing or Plucking
__ Electrolysis or Threading
__ Recent Sunburn or Tan (Including Tanning Bed)

What is your ethnic background? _________________________________

When Exposed to the sun, do you usually: __ Always Burn, Never Tan __ Burn Easily, Tan Poorly __ Tan after Initial Burn

__ Burn Minimally, Tan easily __ Rarely Burn, Tan Dark Easily __ Never Burn, Always Tan Dark

List any special skin care products you use including retin-a, retinol, anti-aging products:

____

Client Signature: ____ Date: __________________________

Parent or Guardian (if patient is under 18 years of age): ____

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FEMALE HEALTH ASSESSMENT QUESTIONNAIRE

NAME: ______________________ EMAIL: ______________________

TODAY'S DATE: ______________________ PHONE: ______________________

Please mark the appropriate box for each symptom you may be experiencing.

SYMPTOMS	NONE	MILD	MODERATE	SEVERE	VERY SEVERE
Physical Exhaustion (fatigue, lack of energy, stamina or motivation)	☐	☐	☐	☐	☐
Sleep Problems (difficulty falling asleep or sleeping through the night)	☐	☐	☐	☐	☐
Irritability (mood swings, feeling aggressive, angers easily)	☐	☐	☐	☐	☐
Anxiety (feeling overwhelmed, feeling panicky, or feeling nervous)	☐	☐	☐	☐	☐
Decline in drive or interest (loss of "zest for life," feeling down or sad)	☐	☐	☐	☐	☐
Joint and muscular symptoms (joint pain, muscle weakness, poor recovery after exercise)	☐	☐	☐	☐	☐
Difficulties with memory (concentration, finding the right word, or retaining information)	☐	☐	☐	☐	☐
Vaginal dryness or difficulty with sexual intercourse	☐	☐	☐	☐	☐
Sexual Problems (change in desire, activity, orgasm and/or satisfaction)	☐	☐	☐	☐	☐
Sweating (night sweats or increased episodes of sweating)	☐	☐	☐	☐	☐
Hot Flashes (burst that starts in chest and lasts for short duration)	☐	☐	☐	☐	☐
Hair loss, thinning or change in texture of hair	☐	☐	☐	☐	☐
Feeling cold all the time, having cold hands or feet	☐	☐	☐	☐	☐
Headaches or migraines (increase in frequency or intensity)	☐	☐	☐	☐	☐
Weight (difficulty losing weight despite diet/exercise)	☐	☐	☐	☐	☐
Bladder problems (difficulty in urinating, increased need to urinate, incontinence)	☐	☐	☐	☐	☐

Other symptoms or unique health circumstances to take into consideration:

General Consent

Thank you for choosing Vita Sana Clinic. On our ongoing efforts to provide you with the best possible service, we ask that you carefully review this consent form and ask any questions necessary to help you fully understand it. This form shall serve as a permanent consent form along with each and every procedure consent form signed by you for services rendered by Vita Sana Clinic.

Anesthesia

I understand that use of a topical anesthetic is optional and will only be applied upon my request. I understand that the topical anesthetic is designed to decrease my sensation of discomfort associated with the carious treatments.

I also understand that individual variance and equipment settings will affect any perceived level of discomfort.

I will fully disclose my personal medical history, including any medications I may be taking, in order to assist with the choice, if any, of topical anesthesia.

If using an over-the-counter (non-prescription) topical anesthetic product I assume all risks associated with its use and will discuss such use with my pharmacist or personal physician prior to application. This includes any product obtained through or at the recommendation of Vita Sana Clinic.

If using a prescription product, I will review its use with the prescribing physician and with the dispensing pharmacist. I will not use such a product until ai am fully informed of its need, potential complications and cautions associated with its use.

I understand that, in general, topical anesthetics are not to be used by anyone allergic to “Caine” type medications, anyone who is pregnant or nursing, or anyone with a history of seizure or liver disease. Topical anesthetic is not to be used on damaged or non-intact skin, open sores, or inside the mouth. I will obtain and review any product-specific cautions and information prior to using the medication.

Disclosure

I will disclose a full and accurate personal medical history to include any and all information regarding medical conditions and my use if medications, drugs, herbs, vitamins, or other supplements of any kind. I understand that failure to do so may affect my treatment outcome and increase the likelihood or severity of complications.

Confidentiality

I understand that no information regarding services performed shall be released without my express consent except as herein stated. I understand that, in addition to authorized Vita Sana personnel, the clinic’s Medical Director and Consulting Physicians shall have full access to my treatment records. I also understand that appropriate medical assessment may be conducted to further the safety and efficacy of Vita Sana Clinic services. I understand that there may be a charge for my medical assessment. I understand that Vita Sana Clinic will maintain file copies of all records.

Continued Consent

I understand that Vita Sana Clinic services consist of ongoing treatments to achieve maximum benefit, and this consent shall apply to all services rendered to me by Vita Sama Clinic, including ongoing or intermittent treatments.

Photographs

I understand that photographs may be taken to document treatment results, however, they will not be released or used otherwise without my specific verbal or written consent.

Guarantee

I understand that no specific guarantees are implied or made by this consent form.

I certify that I am a competent adult of at least 18 years of age.

My signature attests to the fact that I have fully read this entire consent form and that any questions or concerns have been answered to my satisfaction, and that I understand and agree to the information contained within.

Date: ______________________

Signed: ____

Printed Name: _______________________________________

Parent or Legal Guardian: ______________________________ (for minors under age 18)

Patient Photographic Consent and Release

I, ________________________________ consent to the taking of photographs and/or video by Dr. Burgess or her designee, of me or parts of my body for medical documentation purposes.

I understand that such photographs may be published in any print, visual, or internet media, specifically including but not limited to medical journals and textbooks, for the purpose of informing the medical profession or the general public about surgical methods. This includes but is not limited to print, non-print, all languages, world rights, subsequent editions, and derivatives, such as promotional material or online platforms.

Neither I, nor any member of my family will be identified by name in any publication. I understand that in many circumstances the photographs may portray features which shall make my identity recognizable. I may revoke consent at any point in the future should I choose. Photos available in public forums (social media) can be copied by other people/ entities despite watermarking, and this may be objectionable.

I release and discharge Dr. Burgess and associates and all parties acting under their license and authority from all rights that I may have in such photographs and from any claim that I may have relating to their use in such publication, including any claim for payment in connection with distribution or publication of photographs. I understand that I will receive no compensation for these photographs.

Patient consultations
Presentations/Publications
Social Media (e.g. to include Instagram__, blogs__, websites__, Facebook__)

I grant this consent voluntarily and certify that I have read and understood the above Consent and Release.

______________________________________ ______________________

Signature of Patient or Legal Guardian **Date**

______________________________________ ______________________

Signature of Physician or Witness **Date**

No Show Fee

In order to assure that all of our patients receive the best care possible, our clinic asks that all rescheduled appointments and cancellations are made within 48 hours of the scheduled appointment time.

I, ________________________ , understand that there will be a $75 fee for rescheduled appointments and cancellations made within less than 48 hours of any scheduled appointment time. Appointments rescheduled or cancelled with less than 24 hours the patient will be charged 50% of the procedure fee.

- I agree to reschedule appointments and make any cancellations, that may be necessary, 48 hours prior to scheduled appointment times.
- I understand if failure to do so, I will be charged a $75 fee or 50% of procedure depending upon time prior to scheduled appointment.

______________________________ Patient Signature

______________________________ Date