BELLAIRE DERMATOLOGY

PATIENT INFORMATION

Date……

Name…… Date of Birth……
Home Address……...
City…… State…… Zip……
Home Telephone…… Cell……
Email……..……
How did you hear about us? ……..

What are your primary cosmetic goals/concerns today?
……..……...
……..……...
……..……...
……..……...
……..……...

Are you planning to attend a special event (wedding, reunion, other)? If so, when?
……..……...
……..……...

Have you had prior cosmetic treatment or surgery?.....Type…….

Skin Care Regimen

Skin Type: ☐ Caucasian ☐ African – American ☐ Hispanic ☐ Asian ☐ Indian ☐ Other

AM Routine	PM Routine
……..	……
……..	……
……..	……
……..	……

Besides the purpose of today's visit, please tell us what you would like to hear about.

Circle all that apply:

Aesthetics	**Body Contouring**	**Injectables**
Skin Care Advice	Fat Reduction	Wrinkles and Fine Lines
Skin Care Products	Non-Surgical Buttocks Lift	Thin Lips
Chemical Peels	Muscle Toning	Facial Volume Loss
Acne	Double Chin/Jowl	Neck Wrinkles
Eyebrow Microblading	Skin Laxity	Under Eye Circles
Dermaplaning		Drooping Brows
		Drooping Eyelids
		Jaw Contouring
		Excessive Sweating
		Loss of Contour
Devices or Laser Treatments	**Vein Therapy**	**Other Offerings**
Acne Scars/Scar Treatments	Facial Veins	Hair Loss
Facial Redness	Varicose Veins	Clinical Trial Participation
Brown Spots/Freckles	Spider Veins	Mole Removal
Unwanted Hair		
Uneven Texture or Color		
Skin Laxity		
Wrinkling		

Medical History

Primary Physician……

Do you smoke?	☐ Yes	☐ No	If yes, how much?…… ……
Do you drink?	☐ Yes	☐ No	If yes, how much?…… …
Currently Pregnant?	☐ Yes	☐ No	
Trying to Conceive?	☐ Yes	☐ No	
Currently Nursing ?	☐ Yes	☐ No	
Menopause?	☐ Yes	☐ No	If yes, age……

What medications, vitamins, and/or herbal supplements are you currently using?

……

……

Health or Chronic Issues
Select all that apply:

Seizure/Epilepsy	☐ Yes ☐ No	Recent/Sch Dental Work	☐ Yes ☐ No
Recent/Sch Vaccines	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No
Heart Failure	☐ Yes ☐ No	Cold Sores/Fever Blisters	☐ Yes ☐ No
Heart Attacks	☐ Yes ☐ No	Facelift	☐ Yes ☐ No
Stroke or Paralysis	☐ Yes ☐ No	Bleeding Tendency	☐ Yes ☐ No
Hepatitis	☐ Yes ☐ No	Asthma/Emphysema	☐ Yes ☐ No
Anorexia	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Easy Bruising	☐ Yes ☐ No
Anxiety	☐ Yes ☐ No	Bipolar Disorder	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Kidney Trouble	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No	Gi Issues/Reflux	☐ Yes ☐ No
Depression	☐ Yes ☐ No	Body Image Problems	☐ Yes ☐ No
Eyelid Sugry	☐ Yes ☐ No	Obsessive Compulsive Disorder	☐ Yes ☐ No
Panic Disorder	☐ Yes ☐ No	Last Skin Exam Date:_.....	
HIV/AIDS	☐ Yes ☐ No	Cancer? Type:……	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No		

Have you been under psychiatric care? ☐ Yes ☐ No

Are you under current psychiatric care now? ☐ Yes ☐ No

Notes:
……
……
……
……

I have read this questionnaire and have disclosed my medical history to the best of my knowledge.

Patient Signature…… Date……

PERSONAL TREATMENT PLAN

Date……

Name……

Prior Treatment(s)……

Were you Satisfied?.....

Goals

Goal #1..... Target Date.....
Goal #2..... Target Date.....
Goal #3..... Target Date.....

Treatment and Budget Plan

Tx#	Mo/Yr	Treatment	Budget Range
1.....			
2.....			
3.....			
4.....			
5.....			
6.....			
7.....			

Product and Homecare Plan

AM Routine	PM Routine
……..	……
……..	……
……..	……
……..	……

Provider Name……..……..……

Provider Signature……..……...