344 Beauty Bar

Cosmetic Interest Questionnaire

Name:

Address: **Zip Code:**

Telephone: Email:

Please e-mail me information on special offers and events!

Yes_____ No_____

Are you a Brilliant Distinctions Member? Yes_____ No_____

Are you interested in a cosmetic Ladies Night Out? _____

Birth Date:

How did you hear about us? (circle one below)

Magazine Newspaper Billboard
Radio Groupon Sign out front
Friend Family Employee

Which friend referred you? _____

Other, Please Specify:

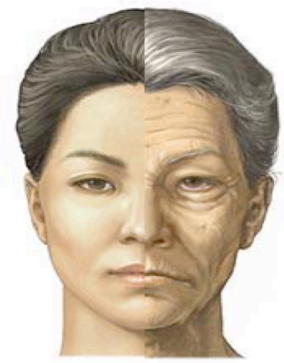
These are the areas of concern for me:

- ☐ Fine Lines and wrinkles
- ☐ Frown Lines between the brows
- ☐ Wrinkles / Lines around nose and mouth
- ☐ Length / Thickness of eyelashes
- ☐ Texture of skin / Pore Size
- ☐ Facials and eye treatments
- ☐ Facial Veins
- ☐ Spider Vein Treatment
- ☐ Hair Removal
- ☐ Removing Leg Veins
- ☐ Age Spots / Liver Spots
- ☐ Birthmarks
- ☐ Skin Care Products
- ☐ Skin Care Advice
- ☐ Sagging / Loose skin
- ☐ Uneven skin tone
- ☐ Acne
- ☐ Unwanted Hair
- ☐ Dark circles under eyes
- ☐ Freckles / Sun Damage
- ☐ Dryness
- ☐ Cellulite
- ☐ Other_____

Ranking of concerns:

1.
2.
3.
4.
5.
6.
7.

Please feel free to mark areas of concern on facial diagram.



Other Comments:

When looking at my face in the mirror, I believe I look younger, the same as, or older than my true age.

Younger Than *True Age* *Older Than*

1 2 3 4 5

When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of my wrinkles.

Not Concerned *Somewhat Concerned* *Very Concerned*

1 2 3 4 5

Signature:

Cosmetic/Aesthetic History

Please circle applicable answers:

1. How would you describe your skin? Sensitive Resilient Not sure
2. Describe your skin type:
   oily large pores/oily combination oily/dry normal dry very dry
3. What products or medications do you currently use on your face?
   _____
4. Have you ever had any laser or light based treatment?
   No Yes Type(s) _____
5. Do you sun bathe, go to tanning beds or use tanning lotion? No Yes If yes, when was your last exposure?_____
6. Do you have issues with hyper/ hypo pigmentation? (or marks after physical trauma)
   No Yes If so, explain_____
7. Have you ever had any facial surgery performed? No Yes Type:_____
8. Have you ever had any type of Aesthetic Procedure/Treatment (including ablative laser)?
   No Yes Type:_____
9. Have you ever had any complications with any Aesthetic Procedures/Treatment in the past?
   No Yes If so, what?_____
10. Have you ever had any of the following injectable?
    BOTOX Juvederm Voluuma Other_____

Medical and Family History

1. Are you currently under the care of a physician? No Yes, For: _____
2. Are you currently under the care of a dermatologist? No Yes, For: _____
3. Do you have any of the following medical conditions? (Please circle all that apply):

Cancer	Diabetes	High Blood Pressure	Herpes
Cold Sores	Skin Disease/Lesion	Autoimmune Disease (Ex: Lupus)	Skin Cancer
Seizure Disorder	Hormone Imbalance	Thyroid Problems	Arthritis
Acne	Rosacea	Bleeding Disorder	Breathing Disorder
Keloids/Healing problem	Weakened Immune System	Neuropathy	Acute or Chronic Infection
Depression	Anxiety	Panic Attacks	Open Wound
Frostbite	Raynauds Disease	Cryoglobulinemia	Cold Agglutinin Disease

Please list any other health problems or medical conditions (not listed above):
_____
_____

4. Is there a family history of skin disorders? No Yes, _____
5. Have you had any recent surgeries? _____
6. Do you drink alcohol? No Yes, if so how much/ often?_____
7. Do you smoke? No Yes, if so, how much/ often?_____
8. Do you exercise? No Yes if so how much/often? _____,
9. Are you pregnant? No Yes
10. Are you currently breastfeeding? No Yes
11. Are you planning to become pregnant? No Yes

12. Do you have any allergies to ANY medications or supplements: No Yes
    Please list ALL and indicate type of reaction:
    a. _____
    b. _____

13. Do you have allergies to any of the following? If so please indicate your reaction.
    Latex Food (type):_____ Lidocaine
    Hydroquinone Alpha Hydroxy Acid Sulfa
    If so please describe reaction:
    _____

14. Please list ALL medications (including OTC) you are currently taking: None
    Antibiotics Blood Thinners Birth Control Hormones
    Aspirin NSAIDS (Motrin, Advil, Aleve) Anticoagulants
    Benadryl Zantac Amitriptyline Herbal Supplements
    Accutane (in the past 6 months)
    Others (please list):
    _____
    _____

I have answered this questionnaire to the best of my knowledge. I will update the staff with any changes. I understand the answers to this questionnaire are imperative with provided safe quality service.

Patient Signature_____ Date_____

Reviewed with Patient _____ Date_____

NP/MD Signature_____ Date_____

HIPAA ACKNOWLEDGEMENT/CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);

Obtaining payment from third party payers (e.g. my insurance company);

The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at anytime. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Date Of Birth_____

Print Patient Name _____

Signature_____

Date _____

Relationship to Patient if patient is a minor_____