Beautologie
COSMETIC SURGERY AND MEDSPA

Welcome

Please tell us a little about yourself so that we can achieve our goal of providing you with optimal care.

ABOUT YOU

Today's Date: _____

First Name: _____

Last Name: _____

E-Mail: _____

☐ Add me to your newsletter list

Birth Date: _____

Age: _____ ☐ Male ☐ Female

Home Address: _____

_____

CITY STATE ZIP

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Home #: _____

Cell#: _____

Work#: _____

Employer: _____

Employer Address: _____

_____

CITY STATE ZIP

Occupation: _____

Emergency Contact Name: _____

Emergency Contact #: _____

By naming an emergency contact you authorize our office to speak to this person regarding your personal health information.

Who referred you? _____

☐ Physician ☐ Friend ☐ Newspaper ☐ Yellow Pages ☐ Radio ☐ Magazine

Primary Physician's Name: _____

Primary Physician Phone #: _____

INSURANCE

Insurance Name: _____

Insurance Policy #: _____

Name of Person Insured: _____

Insured Birthday: _____

Insured Employer: _____

WOULD YOU LIKE INFORMATION ON THE FOLLOWING?

☐ **BOTOX® / DYSPORT® / XEOMIN®**
(can soften the appearance of the wrinkles around your eyes, forehead, and frown lines)

☐ **RESTYLANE® / JUVEDERM® / RADIESSE® / OR OTHER FILLERS**
(a filler that can improve the appearance of the larger wrinkles around your face or add fullness to lips)

☐ **PIPL HOTOFACIAL**
(a laser system that can eliminate redness and age spots from your face and treat severe acne)

☐ **LASER RESURFACING**
(a deep laser treatment used to smooth out facial wrinkling and acne scarring)

☐ **LASER HAIR REMOVAL**
(a laser treatment used to reduce or eliminate unwanted hair)

☐ **SKIN TIGHTENING TREATMENTS**
(Venus Freeze® Body Contouring, Aluma™ Skin Tightening or Endermologie® cellulite treatments are non-surgical options to firm, smooth and tighten the skin)

☐ **SKIN CARE / CHEMICAL PEEL**
(a skin care system that can help you eliminate blemishes,acne and the appearance of large pores)

☐ **MICRODERMABRASION**
(improves the appearance of pores and fine lines)

☐ **WEIGHT LOSS**
(non-surgical solutions to help you lose weight)

☐ **LASER TATTOO REMOVAL**
(specialized laser to remove professionally done or amateur tattoos)

☐ **BREAST ENHANCEMENT**
(surgical breast augmentation, lift, or reduction)

☐ **TUMMY TUCK**
(surgical removal of excess skin and fat of the abdomen)

☐ **LIPOSUCTION**
(surgical removal of fat using ultrasound and a small cannula)

☐ **BUTTOCK SURGERY**
(enhancement of the buttocks by inserting fat)

☐ **FACE LIFT OR NECK LIFT**
(surgical removal of a small amount of skin from the face and neck to help eliminate wrinkles)

☐ **EYELID SURGERY**
(removal of loose skin and fat around the eyes)

☐ **RHINOPLASTY**
(improves shape, size and/or symmetry of the nose)

☐ **HAIR RESTORATION**
(surgical options for female and male hair loss)

WOULD YOU LIKE FINANCING INFORMATION?

☐ YES ☐ NO

MEDICAL HISTORY

What procedure(s) are you interested in?:

_____

_____

When would you like to have surgery?

☐ ASAP ☐ Within 3 Months ☐ Other _____

Are you experiencing any of the following problems?

Y	N		Y	N	
○	○	Skin Cancer or Melanoma	○	○	Heavy Periods
○	○	Keloids or Excessive Scarring	○	○	Cramping When Walking
○	○	Cold Sores / Herpes	○	○	History of Blood Clots
○	○	Headaches / Migraines	○	○	Trouble Swallowing
○	○	Numbness / Tingling	○	○	Nausea / Vomiting
○	○	Seizures	○	○	Heart Burn / Ulcers
○	○	Nerve Palsy	○	○	Problems With Anesthesia
○	○	Double Vision / Dry Eyes	○	○	Malignant Hyperthermia
○	○	Easy Bruising / Bleeding	○	○	Neck Problems or Surgery
○	○	Anemia	○	○	Abdominal Pain
○	○	Chronic Cough / Respiratory	○	○	Constipation / Diarrhea
○	○	Infection	○	○	Depression / Anxiety
○	○	TB (Tuberculosis)	○	○	Schizophrenia
○	○	Breathing Difficulty / Asthma	○	○	Manic Episodes / Bipolar
○	○	On CPAP / Sleep Apnea	○	○	Body Dysmorphic Disorder
○	○	Chest Pain / Palpitations	○	○	AIDS / HIV
○	○	Heart Murmur / Valve Problems	○	○	Hepatitis A / B / C
○	○	Pacemaker / Defibrillator	○	○	Excessive Weight Gain / Loss
○	○	Breast Pain or Lumps	○	○	Skin Infections / MRSA

Please list all of your medical illnesses
(diabetes, hypertension, heart disease, lung disease, etc.)

☐ Check here if you have no Past Medical History.

_____

_____

_____

_____

_____

_____

_____

Please list all surgeries you have had done and the month and year these were performed

☐ Check here if you have never had surgery before.
☐ Check here if you have had problems with anesthesia in the past.

_____

_____

_____

_____

_____

_____

_____

Height: _____ Weight: _____

MEDICAL HISTORY

Please list all allergies (medicines, anesthetics, antibiotics, pain medications)

☐ Check here if you have no allergies to medications.

_____

_____

_____

Please list familial medical problems

_____

_____

HABITS

○Y ○N Smoking #packs/day _____

If former smoker, date quit _____

○Y ○N Alcohol #drinks/week _____

○Y ○N Drugs now or in past. Type _____

If in past, date last used? _____

FOR WOMEN ONLY

○Y ○N Are you, or might you be pregnant?

○Y ○N Are you on birth control?

○Y ○N Did you ever breast feed?

○Y ○N Did you ever take hormone replacement?

# of Pregnancies _____ # of Live Births _____

Age of First Period _____ Age of Menopause _____

Date of Last Mammogram _____ Results: _____

(Check with your primary physician as to whether you should obtain a mammogram one month before any breast surgery.)

PLEASE LIST ALL MEDICATIONS THAT YOU ARE TAKING

☐ Check here if you are taking no medications.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Thank you for taking the time to complete this questionnaire. The information you have provided will help us ensure the safe practice of plastic surgery. By signing below you authorize the release of medical information necessary to process insurance claims, you authorize the release of all medical records to/from Beautologie, and you request payment of government benefits and all medical benefits be assigned to Beautologie. You also agree to pay all charges not covered by your insurance. All costs associated with nonpayment including costs associated with the recovery of past dues are the responsibility of the patient. Non-payment will result in additional recovery costs and attorney fees. You also acknowledge you have received a copy of our privacy practices. NO TICE TO CONSUMERS: Medical doctors are licensed and regulated by the Medical Board of California (800-633-2322 www.mbc.ca.gov). By signing below, you acknowledge that you have been given the opportunity to review Privacy Practices of Beautologie and agree to these policies. By signing below, I authorize Beautologie to email, call and text me at the email address and cell number provided with any information, including information regarding my health.

Signature _____ Date _____