Sonterra Dermatology PLLC

History and Intake Form

NAME:_____ **DATE OF BIRTH:**_____

Reason for your visits: _____
_____
How long have you had this problem: _____
Symptoms (How does it bother you): _____
Treatments you have tried: _____

Referred by:
Dr. (Name) _____ Family Member (Name) _____
Friend (Name) _____ Google (X) ____ Yelp (X) ____
Print Ad _____ Website (X) ____ Other_____

Past Medical History: (please circle all that apply)
Anxiety Hepatitis HIV/AIDS None
Other _____

Prior Surgeries: _____

Cancer History:_____

History of Immunosuppression or currently on Chemotherapy:_____

Skin Cancer History and treatment:_____

Skin Disease History: (please circle all that apply)

Acne	Blistering Sunburns	Psoriasis
Actinic Keratoses	Hay Fever/Allergies	Squamous Cell Skin Cancer
Asthma	Melanoma	None
Basal Cell Skin Cancer	Precancerous Moles	

Other _____

Are you pregnant? Yes ☐ No ☐

Medications: (Please enter all current medications)
_____
_____

Allergies: (Please enter all allergies)
_____
_____

Pharmacy: Name:_____
Street:_____ City: _____ State: ____ Zip Code:_____
Telephone #:_____

Sonterra Dermatology PLLC

Cosmetics Questionnaire

Are you interested in discussing any cosmetic treatments during your visit today? (Please circle all that apply)

- Wrinkles (Botox)
- Body Contouring (Coolsculpting/Emsculpt)
- Chemical Peels
- Facial Redness
- Brow Lift
- Fine Lines (Fillers)
- Laser Resurfacing
- Facial/Leg Veins
- Drooping Eyelids
- Under Eye Bags
- Skin Care Advice
- Underarm Sweating
- Blotchy Skin
- Thinning Lips
- Facial/Body Hair Reduction
- Neck Fullness (Double Chin)
- Non-invasive Facial Lift
- Brown/Age Spots or Freckles
- Facial/Body Skin Tightening