SONTERRA DERMATOLOGY plic

History and Intake Form

NAME: _____ **DATE BIRTH: _____**

Reason for your visit: _____

How long have you had this problem: _____

Symptoms (How does it bother you): _____

Treatments you have tried: _____

Referred by:

Dr. (Name)_____ Family/Friend (Name)_____

Google (X)☐ Website (X) ☐ Social Media (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
☐ Actinic Keratoses
☐ Asthma
☐ Basal Cell Skin Cancer
☐ Blistering Sunburns
☐ Hay Fever/Allergies
☐ Melanoma
☐ Precancerous Moles
☐ Psoriasis
☐ Squamous Cell Skin Cancer
☐ None
☐ Other_____

Are you pregnant? Yes ☐ No ☐

Medications: (Please enter all current medications)

_____

Allergies: (Please enter all allergies)

_____

Pharmacy: Name: _____ Telephone #: _____

Street: _____ City: _____ State: _____ Zip Code: _____

Cosmetics Questionnaire

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

- ☐ Wrinkles (Botox)
- ☐ Body Contouring (Coolsculpting/Em sculpt)
- ☐ 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
- ☐ Weight loss