Patient Intake Form for Medical Cosmetic Treatment

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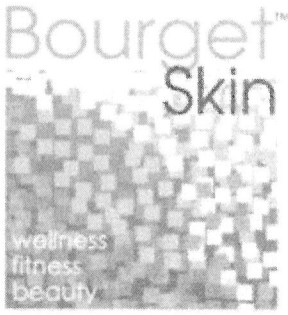

Patient Name _____ DOB ____/____/____ Age _____

Address _____ Apt# _____

City _____ State _____ Zip _____

Cell Phone (____) _____ Work Phone (____) _____ Work Phone (____) _____

Email Address _____

Emergency Contact Name/Phone Number: _____/ (____)_____

May we contact you at home? _____ By Email? _____ By Cell Phone? _____

How were you referred to our practice? _____

Have you ever had any Medical Cosmetic Treatments? _____

Please check off the procedures which are interest to you.

Botox _____ Laser _____ Vein Treatment _____

Cosmetic Fillers _____ IPL _____ Liposuction _____

Others (please specify) _____

Medical History:

What is your usual height and weight? _____

List any medical problems that you have _____

List any medications that you are taking _____

List any allergies that you have _____

List any previous surgeries you have had _____

Patient Signature _____ **Date** _____

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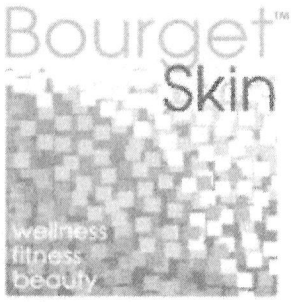

Patient History:

Last Name: _____ First Name_____ MI _____

Birthdate: _____ Age: _____ Sex: _____ SS#: _____

Single: _____ Married: _____ Widowed: _____ Divorced: _____

Home Address: _____ Apt/Unit #: _____

City: _____ State: _____ Zip: _____

Cell Phone: ( ) _____ Home Phone: ( ) _____ Work Phone: ( ) _____

Employer Name: _____ Employer Address: _____

Spouse Name: _____ Spouse Employer: _____

Referred By: _____ Primary Care Physician Name: _____

Primary Care Phone: ( ) _____ Primary Care Address: _____

*Person responsible for bill (if other than above):

Name: _____ Phone: ( ) _____

Address: _____ City: _____ State: _____ Zip: _____

Nearest relative to notify in case of an emergency:

Name: _____ Relationship: _____ Phone: ( ) _____

Address: _____ City: _____ State: _____ Zip: _____

Insurance:

1. _____ Insured ID#: _____ Group #: _____
2. _____ Insured ID#: _____ Group #: _____

I understand all of the above and hereby state the information is correct to the best of my knowledge.

Signed: _____ **Date:** _____
(Patient)

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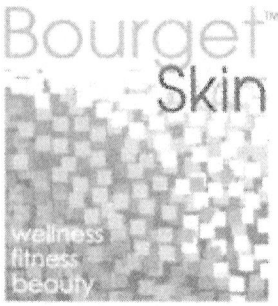

Medical History and Health Information:

These questions are for your benefit and assure that treatment/surgery will take into consideration your past and present health conditions.

Are you in good health? Yes / No

Are you under the care of a physician at this time? Yes / No

If so, what is the condition being treated? _____

Are you allergic to any drugs? Yes / No

Have you ever had any extensive bleeding which required special treatment? Yes / No

Ladies:

When was your last menstrual period? _____

How many pregnancies? _____

Is there a possibility of being pregnant? Yes / No

Are you currently taking birth control pills? Yes / No

Do you use or have you ever used recreational drugs? Yes / No

Do you wear a cardiac pace maker? Yes / No

Are you on a special diet? Yes / No

Do you currently smoke? Yes / No

Please list all medications you are currently taking: _____

Have you ever had any of the following (please circle):

Asthma	Cancer	Chest Pain
Artificial Heart Valve	Blood Transfusion	Emphysema
Cosmetic Surgery	Cortisone medication	Heart Surgery
Diabetes	Dizzy / Fainting	Heart pace maker
Drug addiction	Epilepsy or Seizures	High Blood Pressure
Glaucoma	Heart Failure	Kidney Disease
Hay Fever	Genital Herpes	Nervous Disorder
Hemophilia	Heart Murmur	Rheumatism
Hepatitis B	Heart Attack	Stroke
Hepatitis C	HIV Positive	Sinus Trouble
Leukemia	Liver Disease	Shortness of breath
Psychiatric Treatment	Rheumatic fever	Thyroid Disease
Tuberculosis	Venereal Disease	
Seizures		

List all your surgeries or hospitalizations with dates: _____

Patient Signature _____ Date _____

Reviewed By Dr: _____ Date _____

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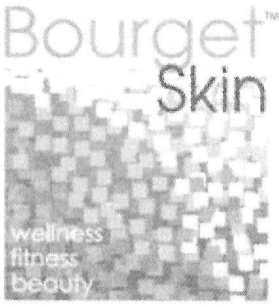

Brief Health Questionaire

Name: _____ DOB: _____ Age: _____

Today's Date: _____ Referring Physician: _____

Medical History:
Please list significant illnesses (such as High Blood Pressure, Heart Disease, Cancer, Diabetes, etc.)

1. _____ Hospitalized? Yes / No
2. _____ Hospitalized? Yes / No
3. _____ Hospitalized? Yes / No
4. _____ Hospitalized? Yes / No

Operations: (Surgery)

1. _____ Reason_ _____ Date: _____
2. _____ Reason_ _____ Date: _____
3. _____ Reason_ _____ Date: _____
4. _____ Reason_ _____ Date: _____
5. _____ Reason_ _____ Date: _____

Medications:

1. _____ Reason_ _____ Date: _____
2. _____ Reason_ _____ Date: _____
3. _____ Reason_ _____ Date: _____
4. _____ Reason_ _____ Date: _____
5. _____ Reason_ _____ Date: _____

Please list any allergies:

_____

_____

Immunizations:

Tetanus (date) _____ Pneumonia (date) _____ Flu (date) _____ Polio (date) _____
Measles (date) _____ Mumps (date) _____ Rubella (date) _____ Others (date)_____

Bourget Skin

Judy L. Bourget, M.D.

SKIN TYPE WORKSHEET

Patient Name: _____

	0	1	2	3	4	Score
What is the color of your eyes?	Light Blue, Grey or Green	Blue, Grey or Green	Blue	Dark Brown	Brownish Black	
What is the natural color of your hair?	Sandy Red	Blonde	Chestnut, Dark Blonde	Dark Brown	Black	
What is the color of your skin? (unexposed)	Reddish	Very pale	Pale with beige tint	Light Brown	Dark Brown	
Do you have freckles on sun-exposed areas?	Many	Several	Few	Incidental	None	
What happens when you stay in the sun too long?	Painful redness, blistering, peeling	Blistering followed by peeling	Burns, sometimes followed by peeling	Rarely burns	Never had burns	
To what degree do you turn brown?	Hardly or not at all	Light color tan	Reasonable tan	Tan very easily	Turn dark brown quickly	
Do you turn brown several hours after sun exposure?	Never	Seldom	Sometimes	Often	Always	
How does your face respond to the sun?	Very sensitive	Sensitive	Normal	Very resistant	Never had a problem	
When did you last expose yourself to the sun or tanning beds?	More than 3 months ago	2-3 months ago	1-2 months ago	Less than 1 month ago	Less than 2 weeks ago	
Do you expose the area to be treated to the sun?	Never	Hardly Ever	Sometimes	Often	Always	

Total _____

Fitzpatrick Skin Type

I (0-7) **II** (8-16) **III** (17-25) **IV** (25-30) **V-VI** (over 30)

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Promoting wellness and cultivating healing

Photographic, Video, Audio and Web Site Consent/Release Form

I do hereby consent and agree that the office of Judy L Bourget MD INC and its staff have the right to take photographs or record video or audio of me (and/or my property) and to use these for educational or promotional materials.

I further consent that my name and identity may be revealed therein or by descriptive text or commentary. Agree_____ Do Not Agree _____

I do hereby release to the office of Judy L Bourget MD INC and its staff all right to exhibit this work publicly or privately, including posting it on a web site. I waive any rights, claims or interests I may have to control the use of my identity or likeness in the photographs, video or audio, and agree that any uses described herein may be made without compensation or additional consideration of me.

I represent that I have read and understand the foregoing statement and am competent to execute this agreement.

Name: _____ Phone: _____

Signature: _____

Date: _____