PATIENT HISTORY QUESTIONAIRE

Name:_____ Date:_____

Check all conditions that you may have.

- ☐ Bleeding Disorders
- ☐ Blood transfusion
- ☐ Chemotherapy
- ☐ Auto Immune Deficiency(AIDS)
- ☐ Circulatory Problems
- ☐ Hyper pigmentation
- ☐ Liver Disease
- ☐ Lupus
- ☐ Melanoma
- ☐ Mental Disorders
- ☐ Hypertension
- ☐ Nerves
- ☐ Ulcers
- ☐ Radiation Treatment
- ☐ Fainting
- ☐ Genital Herpes
- ☐ Hepatitis
- ☐ Infections
- ☐ Phlebitis
- ☐ Respiratory
- ☐ Wound Healing problems
- ☐ Venereal Disease
- ☐ Heart problems
- ☐ Anemia
- ☐ Kidney
- ☐ Asthma
- ☐ Cancer
  Type _____
- ☐ Tuberculosis
- ☐ Cold Sores
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Sinus
- ☐ Stomach
- ☐ Stroke
- ☐ Thyroid
- ☐ **I HAVE NONE OF THESE**
- ☐ Other: _____
  _____

MEDICATIONS/SUPPLEMENTS: (List ALL current medications including birth control, antibiotics, Ginkgo Balboa, Vitamin A, B, or E, Garlic, Flax oil, **ASPIRIN**, etc) _____

_____

ALLERGIES: (List ALL allergies including retinoic acid, latex, cosmetics, milk, sugar/beets, papaya, apples, pineapples, citrus fruits, strawberries, hay fever, bees, eggs, red dyes, hair coloring, etc) _____

_____

HAVE YOU HAD ANY OF THE FOLLOWING: (Please circle YES or NO and list treatment)

Any Retinol products?	YES	NO	Date of last treatment_____
Any glycolic acid or salicylic acid?	YES	NO	Date of last treatment_____
Any hydroquinone or bleaching agents?	YES	NO	Date of last treatment_____
Any Accutane in the past nine (9) months?	YES	NO	Date of last treatment_____
Any prescription for acne?	YES	NO	Date of last treatment_____
Birth Control Pill/Patch?	YES	NO	Date of last treatment_____
Steroids (oral or injection)?	YES	NO	Date of last treatment_____

Please answer the following:

Are you pregnant?	YES	NO	Do you get cold sores?	YES	NO
Are you lactating?	YES	NO	How many times a year _____		
Do you smoke?	YES	NO	Is your skin sensitive?	YES	NO
Do you tend to scar?	YES	NO	Do you form Keloids?	YES	NO

After scabbing is your skin darker in color? YES NO

If you are out in the sun for 2 hours without sun-block you will…..

1) Always burns & never tans **4) Rarely burns & usually tans**

2) Usually burns & rarely Tans **5) Rarely burns but tans**

3) Sometimes burns & tans gradually **6) Never burns and tans quickly**

When was your last sunburn? _____

What is your ethnic background?

_____

Do you use Sunscreen? YES NO

What SPF? 15 30 50+

What would you like information on? Please circle top 3 concerns.

Acne / Acne Scars
Black Heads
Clogged Pores
Dark Circles under Eye
Dull Skin
Leg/Facial Veins
Fuller Lips
Jowls
Melasma
Unwanted Hair
Rosacea
Skin Laxity
Micro-Needling
Chemical Peels
Seborrheic Keratosis
Brown/Black Spots
Tattoo Removal
Freckles
Jaw Pain/TMJ
Longer Eyelashes
Double Chin
Rough / Dry Skin
Permanent Makeup
Skin Care
Teeth Whitening
Cherry Angiomas
Wrinkles
Skin Tags

Please answer the following:

Do you lay out in the sun? Yes No
Do you use a tanning bed? Yes No
Do you use tanning creams? Yes No
Do you get spray tans? Yes No

List all previous surgeries: _____

_____

PREVIOUS COSMETIC TREATMENTS: Please check all that apply.

- ☐ Chemical Peels Date of last treatment _____
- ☐ Microdermabrasion Date of last treatment _____
- ☐ Laser Resurfacing Date of last treatment _____
- ☐ Waxing Date of last treatment _____
- ☐ Eye Lash Extensions Date of last treatment _____
- ☐ Age Spot Removal Date of last treatment _____
- ☐ UV Tanning Beds Date of last treatment _____
- ☐ Laser Hair Removal Date of last treatment _____
- ☐ Facial Surgery Date of last treatment _____
- ☐ Sclerotherapy Date of last treatment _____
- ☐ Botox Date of last treatment _____
- ☐ Derma Fillers Date of last treatment _____
- ☐ Micro-Needling Date of last treatment _____
- ☐ Permanent Make-up Location(s) _____

Please comment any negative outcomes to prior treatments:

_____

_____

_____

4421 IRVING BLVD NW, SUITE C
ABQ, NM 87114 PH: 505-897-4433/ F: 505-897-3085

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT & HEALTHCARE OPERATIONS

Patients Name: _____ Date of Birth: _____

I consent to the use and disclosure of my protected health information (PHI) by Belleza Med Spa for the purpose of diagnosing or providing treatment to me, obtaining payment for services rendered, or as necessary to conduct health care operations of Belleza Med Spa. I understand that diagnosis or treatment of me by any physician of Belleza Med Spa may be conditioned upon my consent as evidenced by my signature of this document.

I understand that I have the right to request a restriction as to how my PHI is used or disclosed to carry out treatment, payment or healthcare operations of this practice. Belleza Med Spa is not required to agree to the restrictions that I may request. However, if Belleza Med Spa agrees to restrictions they are binding on Belleza Med Spa and any physician of Belleza Med Spa.

I have the right to revoke this consent in writing at any time, except to the extent that any physician of Belleza Med Spa or other employees of Belleza Med Spa have taken action in reliance on this consent.

My 'protected health information" PHI, means health information, including my demographic information, collected from me and created or received from my physician, another health care provider, a health plan, my employer or a health care clearing house.

This PHI relates to my past, present and future physical or mental health or condition that identifies me, or that there is a reasonable basis to believe the information may identify me.

I understand that I have the right to review Belleza Med Spa's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the type of uses and disclosures of my PHI that will occur in my treatment, payment of my bills or in the performance of healthcare operations of Belleza Med Spa. This Notice of Privacy Practices also describes my rights and Belleza Med Spa's duties with respect to my PHI.

Belleza Med Spa reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain revised notice by calling the office and requested a revised copy and have it sent via mail or to pick up at my next appointment.

_____

(Signature) (Date Signed)

_____

(Signature of Personal Representative, if patient is unable to sign or under 18 years of age.)

PATIENT AUTHORIZATION FOR PHOTO/VIDEO PURPOSES

(Please read each bullet and initial the appropriate line(s) and complete bottom portion of form.)

_____ I hereby authorize Belleza Med Spa to take photographs, videotapes or digital images of me **for document purposes only**. (This line must be initialed)

_____ I understand that Belleza Med Spa may use and release my images to the general public for the following purposes: (1) educational lectures and presentations for health care professionals; (2) scientific publications such as journals or books; (3) patient education materials; (4) broadcast, print or internet media for educational or public interest purposes. I understand my identity will not be given away unless authorized for Latisse.

_____ I understand that after release of my images to the general public, they may be subject to re-disclosure.

_____ Unless otherwise revoked, I understand that this authorization will expire 50 year(s) from the date of signature. I understand that I may revoke this authorization at any time, except to the extent that Belleza Med Spa has relied on this authorization, by sending a written statement of revocation that specially refers to this authorization to:

_____ I give consent to allow Belleza Med Spa to post photos/videos of me on social media platforms (i.e. Facebook, Instagram, etc.).

I hereby release Belleza Med Spa and its officers, heirs, legal representatives, agents, employees and all persons functioning under Belleza Med Spa's permission or authority or those for whom Belleza Med Spa is functioning from any and all liability connected with the capture, use or release of my images.

By signing this authorization I acknowledge that I have read and understand the statements contained herein. I understand that Belleza Med Spa will provide me with a copy of this signed authorization form should I request one.

Print Name: _____

Signature: _____

Date: _____

If Patient has a Legal Representative, complete the following:

Print Name of Legal Representative: _____

Relationship to patient: _____

Signature of Legal Representative: _____ Date: _____

Belleza MEDSPA

PATIENT INFORMATION SHEET

(PLEASE PRINT)

Name: _____ Date of Birth: _____ Age: _____

Address: _____

City: _____State: _____Zip: _____

Home Phone: _____Cell Phone: _____

Work Phone: _____ Occupation: _____

Email Address: _____

Emergency Contact Name: _____ Emergency Phone: _____

Responsible Party Information

(Only if Patient is NOT responsible Party)

Name: _____Address:_____

City:_____State:_____Zip:_____Phone: _____

Relationship to Patient: _____

How did you hear about us?

- ☐ Walk In / Drive by
- ☐ Online / Website
- ☐ Bliss Salon & Spa
- ☐ Attractions Hair Studio
- ☐ Newspaper
- ☐ Craig's List / Facebook
- ☐ Personal Reference (who?) _____
- ☐ Business card
- ☐ Mailer
- ☐ Union Newsletter
- ☐ Coupon
- ☐ Phonebook
- ☐ Booth
- ☐ Other _____

Name: _____

AUTHORIZATION TO RELEASE INFORMATION

I authorize the physician and staff of Belleza Med Spa to discuss my medical condition, treatment plan or any relevant subject with (i.e. husband, sister)

Name(s) _____

_____ (Please Initial)

APPOINTMENT CONFIRMATION

I give Belleza Med Spa permission to confirm and leave appointment information on my answering machine or voicemail.

- ☐ Yes
- ☐ No

_____ (Please Initial)

I would like Belleza Med Spa to leave the appointment confirmation on my…

- ☐ Cell Phone
- ☐ Home Phone

_____ (Please Initial)

PRIMARY CARE PHYSICIAN

Name: _____ Phone: _____

DERMATOLOGIST

Name: _____ Phone: _____

REFUND POLICY'S

Refunds may be granted on unused service(s) with a 20% processing fee. _____**(Initial)**

All skincare products are final sale. _____**(Initial)**

If you cancel, re-schedule or no show for an appointment within 24 hours of your scheduled time, your credit card may be charged the total amount of treatment scheduled for that day. _____**(Initial)**

Your credit card will be charged $50 for a no show/ no call on the day of your consultation and may re-schedule within 24 hours of your consultation. _____**(Initial)**

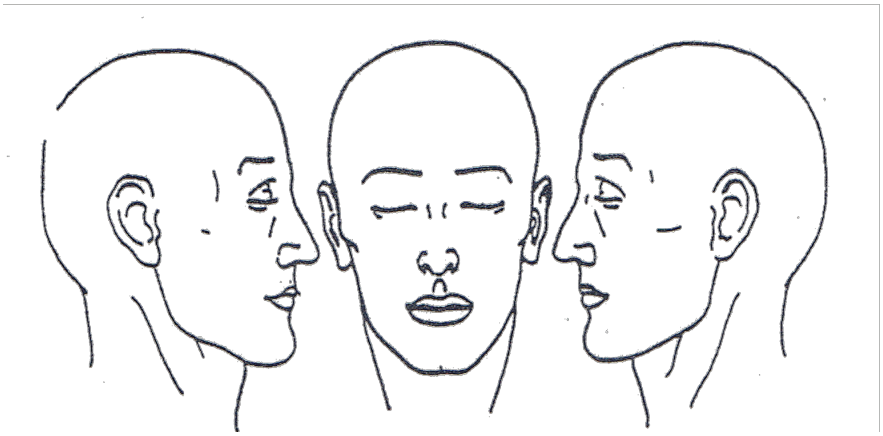
If you no show/ no call for an appointment you will be required to pay a deposit prior to scheduling again. _____**(Initial)**

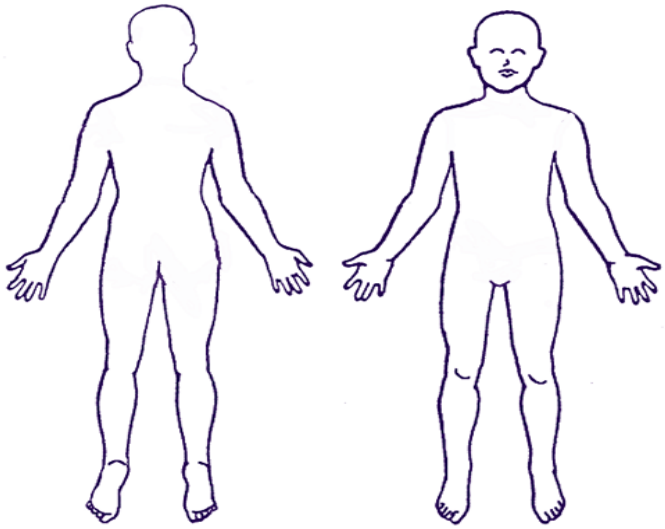
If you are more than 5 minutes late for an appointment we will do our best to accommodate you, but will have to re-schedule your appointment for another time. _____**(Initial)**

We are unable to watch children for you during your treatment. If you are not able to attend your appointment without your child(ren) please re-schedule your appointment. _____**(Initial)**

PATIENT INDICATION SHEET

On the mannequin below, mark an "**X**" on all areas of concern.





Notes:_____

_____

_____

_____

_____

Oily ____ Dry ____ Combination ____

Exfoliating ____ per week.

Acne. All the time

Alcohol/Phone

Change Pillowcases