

BUBOLO MEDICAL

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Aesthetics Patient Questionnaire and History

Name: _____ Today's Date: _____
(Last) (First) (Middle)

Date of Birth: _____ Age: _____ Weight: _____ Occupation: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work: _____

E-Mail Address: _____ May we contact you via EMail? () YES () NO

In Case of Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work: _____

Who may we thank for referring you to our clinic? _____

I want to unlock exclusive offers by subscribing to the monthly newsletter

- Yes
 No

I _____ grant my permission for the use of photographs, videos or case information for the following Bubolo Medical clinical purposes as indicated by my checked box below:

- Allow my picture to be used with identifying information
 Only allow my pictures to be used without identifying who I am
 I do not want any of my photos and or videos used

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Medical History

ALLERGIES? () YES () NO - If yes, please explain _____

Current prescriptions, OTC medications, vitamins or supplements:

Surgeries, list all and when:

Hormones/Sexual Health

Female:

Regular periods _____yes _____no Date of last menstrual cycle: _____

Menopausal? _____yes _____no

Currently taking birth control? _____yes _____no

Are you currently lactating? _____yes _____no

Is there a chance you could be pregnant? _____yes _____no

Are you trying to become pregnant? _____yes _____no

Current Hormone Replacement Therapy: _____

Past Hormone Replacement Therapy: _____

Male:

Date of last Prostate Exam: _____

Result: _____

Current Hormone Replacement Therapy: _____

Past Hormone Replacement Therapy: _____

Pigmentation: () Even () Uneven () Birthmark () Pregnancy mask/Melasma

Vascularity:

_____Nose

_____Chin

_____Entire Face

_____Cheeks

_____Forehead

Acne:

_____Pimples

_____Acne Scars

_____Blackheads

_____Flakiness

_____Enlarged pore

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**INDICATE IF YOU ARE BEING TREATED OR HAVE BEEN TREATED FOR ANY OF THE FOLLOWING CONDITIONS:
please circle all that apply**

Arthritis	Diabetes	Poor Circulation
Autoimmune Disorder	Heart Disease	Stroke
Blood Clot/ Pulmonary Embolism	High Blood Pressure	Eczema
Cancer	High Cholesterol	Psoriasis
Chronic liver disease	HIV/AIDS	Rosacea
Fibromyalgia	Kidney Disease	Hernia
Glaucoma	Migraines/Headaches	Thyroid Disease
Heart Attack	Neuromuscular Disorder	Facial Surgery/ Implant
Excessive Bleeding/Bleeding Disorder	PCOS	
Other: _____		

Personal Skin Health History:

Do you drink alcohol? ___yes ___no How often? _____

Do you smoke? ___yes ___no How often? _____

Are you being treated by a Dermatologist? _____

Last Visit? _____

Are you being treated for skin conditions on your face? _____

Explain _____

Are you taking Accutane or have you had Accutane within the last 6 months? ___yes ___no

Do you get cold sores? ___yes ___no Last lesion? _____

Do you get Keloid Scars? ___yes ___no Location? _____

Do you bruise easily? ___yes ___no Location? _____

Do you have any metal implants, IUDs, Screws, Vaginal/Bladder Mesh etc?

What skin-care products are you currently using?

Do you have any family history of hair loss/thinning? If so, what is the relationship to you and how would you describe the condition?

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- () Botox - Last treatment date _____
- () Dermal Fillers - Last treatment date _____
- () Chemical Peels - Last treatment date _____
- () Laser Treatments - Last treatment date _____
- () Microneedling - Last treatment date _____
- () Latisse
- () Previous Aesthetic or Reconstructive Procedures? _____
- () Are you currently using any skin care products that contain:
 - () Glycolic Acid () Lactic Acid () Hydroxy Acid () Retin-
- () Skin Product Sensitivities - explain _____

What do you want to improve?

- () Fine lines/Wrinkles
- () Worry Lines
- () Deep Lines
- () Marionette Lines
- () Acne
- () Scars/Acne Scars
- () Large Pores
- () Sun Damage
- () Redness
- () Hyperpigmentation/Dark Spots
- () Cellulite
- () Stretch Marks
- () Hair Thinning/Hair Loss
- () Fatty Tissue
- () Laxity/Skin Tightening
- () Vaginal Tightening

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PATIENT AUTHORIZATION FOR CONTACT & DISCLOSURE OF PROTECTED HEALTH INFORMATION

THIS FORM INSTRUCTS US WHO ELSE SHOULD GET YOUR MEDICAL INFORMATION. YOUR DOCTORS ARE ALWAYS INFORMED, SO DO NOT LIST THEM.

1. I authorize Bubolo Medical to disclose my protected health information to:

Family member(s)

Name	Phone Number

Non- Family Members

Name	Phone Number

Myself Only

2. I authorize the practice to disclose only the following protected health information to the individual(s) listed above:

- Test results, reports, and general health updates
- Nothing beyond general health questions & updates

3. I may be contacted with medical information by:

Email Address:
Phone Number:

Patient Signature _____ **Date** _____