BEALS
PLASTIC SURGERY | SKIN AND LASER

Personal Information

Today's Date

Name (Last, first, middle initial)

Date of Birth

Street address City State Zip Code

Primary phone number | Cell phone number | Work Phone

Email address

Emergency Contact Information

Name Phone Relationship

Where Did You Hear About Us (please be specific)

Magazine_____ Internet_____ Referral_____

Other_____

MEDICAL HISTORY (Check appropriate box next to any condition for which you have ever been treated.)

☐ ACNE	☐ HIRSUTISM	☐ SHINGLES
☐ ARTHRITIS	☐ VITILIGO	☐ SKIN PIGMENTATION
☐ AUTOIMMUNE DISORDER	☐ KIDNEY DISEASE	☐ STEROID OR HORMONAL THERAPY
☐ BLOOD DISORDERS	☐ MELANOMA/SKIN CANCER	☐ HORMONAL IMBALANCES
☐ CANCER (OR RADIATION THERAPY)	☐ HEPATITIS B	☐ PSORIASIS
☐ DIABETES	☐ PACEMAKER	☐ KELOID SCARS/OTHER SCARS
☐ HERPES (OR COLD SORES)	☐ HIV	

Products you are using on your skin:

Cleanser_____ **Toner**_____ **Moisturizer**_____

Exfoliant _____ **Retinol** _____ **Sunscreen** _____

Other _____

ADDITIONAL QUESTIONS:

1. Are you currently being treated for any conditions not listed? If yes, please specify.

   _____
   _____
   _____
   _____

2. Are you currently taking any medications, including herbal preparations, medical patches or ASA? If yes, please specify.

   _____
   _____
   _____
   _____

3. Do you have any allergies? If yes, please specify.

   _____
   _____
   _____
   _____

4. Have you ever used (or are currently) using Retin-A, Glycolic Acid, or Azelaic Acid? If yes, please specify.

   _____
   _____
   _____
   _____

5. Have you ever used (or are currently using) Accutane? If yes, please specify.

   _____
   _____
   _____
   _____

6. Have you ever had a chemical peel? If yes, please specify.

   _____
   _____
   _____
   _____

7. Have you had any laser treatments? If yes, please specify.

   _____
   _____
   _____
   _____

8. Do you have any dental or acrylic implants, crowns or bridgework? If yes, please specify.

   _____
   _____
   _____
   _____

9. Do you have any tattoos or permanent makeup in the area to be treated? If yes, please specify.

   _____
   _____
   _____
   _____

10. Do you have a pacemaker?

    _____
    _____
    _____
    _____

11. Have you ever been treated by an endocrinologist (Hormone Imbalance)? If yes, please specify.

    _____
    _____
    _____
    _____

12. Do you sunbathe or use self-tanning lotions or use tanning beds? If so, then how often?

    _____
    _____
    _____
    _____

13. Have you ever had gold therapy (used for rheumatoid arthritis)?

14. Are you currently pregnant? Nursing?

15. Have you had any injectables in the area to be treated?

16. Do you have any particular skin sensitivities? Allergies? If so, please specify.

I Have Concerns With **(Please check all that apply)**

□ **Lines – *Botox*** relaxes the muscles in the face in order to help erase lines over time. If your schedule allows downtime, Laser Resurfacing provides dramatic rejuvenation to the entire face.

□ **Loss of Volume –** Fillers such as ***Juvederm*** and ***Voluma*** can help erase lines anywhere on the face instantly and over time.

□ **Hyper Pigmentation – *Photofacials*** and ***Chemical Peels*** significantly diminish sun damage with limited downtime.

□ **Acne – *Chemical Peels, Lasers*** and ***Skin Care Products*** can reduce severity and frequency of breakouts.

□ **Skin Texture – *Dermaplaning*** exfoliates the skin and removes vellus hair (peach fuzz). ***Micropeels*** and some other peels exfoliate the skin and infuse it with customized nutrient solutions. If your schedule allows downtime, a series of ***ProFractional*** or ***MicroLaser Peels*** can greatly improve the texture and appearance of your skin.

□ **Scarring** – ***Non-Ablative Lasers*** and ***Microneedling*** can improve the appearance of scars and reduce redness.

□ **Veins – *Vascular Laser*** can treat veins with minimal discomfort.

□ **Unwanted *Hair*** – ***Laser*** and ***BBL Hair Removal*** reduces hair growth and density.

□ **Skin Care Regimen** – Our aestheticians can customize a home care routine tailored specifically for your concerns with our medical grade products.

AUTHORIZATION TO RELEASE/EXCHANGE PATIENT INFORMATION VIA TEXT MESSAGE OR EMAIL

I _____ authorize the Skin and Laser Center to transfer patient information pertaining to myself electronically via the following methods:

_____ Text Messaging
Initials

_____ Email
Initials

PHOTOS

I give permission to have my photos used for:

☐ www.bealsmd.com _____
Initials

☐ In-office use _____
Initials

☐ Presentations _____
Initials

(For Office Use Only)

NOTES:

Patient's Printed Name _____Date_____

Patient's Signature _____ Date _____

Technician's Signature _____ Date _____