Dr. Padma's AESTHETICS

NAME:	DOB
ADDRESS:	
CITY:	ZIP:
PHONE NUMBER:	
EMAIL:	

- How did you hear about us? _____
- What Services are you interested in? _____

1. WHAT ARE YOUR MAIN CONCERNS? (Check all that apply)

☐ **Acne** ☐ **Acne Scarring** ☐ **Aging** ☐ **Dry Skin** ☐ **Scars**

☐ **Enlarges pores** ☐ **Hyperpigmentation** ☐ **Spider Veins** ☐ **Wrinkles** ☐ **Cellulite**

☐ **Dark circles** ☐ **Sagging Facial Skin** ☐ **Sun Damage** ☐ **Excess Hair** ☐ **Hair Loss**

☐ **Uneven Skin texture/tone** ☐ **Vaginal Health/Rejuvenation**

2. What is your Skin type:

☐ **Normal** ☐ **Oily** ☐ **Dry** ☐ **Sensitive** ☐ **Acne** ☐ **Combo:**_____

3. Are you currently taking medication for a skin condition?(Check all that apply)

☐ **Accutane** ☐ **Retin-A** ☐ **Hydroquione or Bleaching agent** ☐ **Antibiotics:**

Please answer all of the following questions: (CHECK ALL THAT APPLY)	YES	NO
1. Do you have **ANY** current or chronic medical illnesses?		
2. Do you have **ANY** current or chronic skin conditions?		
3. Are you currently under the care of a doctor? (If so for what)		
4. Do you take/use **ANY** MEDICATIONS (prescriptions/non-prescriptions), vitamins, herbal or natural supplements on a regular basis? Please List:		
5. Have you ever had Gold Therapy Treatment(chrysotherapy, aurotherapy, Gold sodium thiomalate(GST))?		

MEDICAL HISTORY, CONTINUED

		YES	NO
7.	Do you take/use ANY systemic/oral steroids (e.g., prednisone, dexamethasone)?	☐	☐
8.	Do you have **ANY** allergies to medications, foods, latex or other substances? Please List:	☐	☐
9.	(For women) are you or could you be pregnant?	☐	☐
10.	(For women) are menstrual periods regular, or have you ever been diagnosed with Polycystic Ovarian Disorder?	☐	☐
11.	Do you have a history of herpes I or II in the area to be treated?	☐	☐
12.	Do you have a history of keloid scarring or hypertrophic scar formation?	☐	☐
13.	Do you have a history of light induced seizures?	☐	☐
14.	Do you have any open sores or lesions?	☐	☐
15.	Do you have any history of radiation therapy in the area to be treated?	☐	☐
16.	In the last six (6) months, have you used any of the following: anticoagulants or blood-thinning medications; photosensitizing medications; or anti-inflammatory or blood thinning medications? Please List product name and date last used:	☐	☐
17.	In the last three (3) months, have you used any of the following products: glycolic acid or otheralphahydroxy or betahydroxyacid acid products; exfoliating or resurfacing products or treatments? Please List product name and date last used:	☐	☐
18.	Do you have or have you ever had any permanent make-up, tattoos, implants, or fillers,including, but not limited to, collagen, autologous fat, Restylane®, etc.? If yes, please list locations on or in the body and dates:	☐	☐
19.	Do you have or have you ever had any Botulinums, such as Botox® or Dysport®? If yes, please list locations on or in the body and dates:	☐	☐
20.	Have you taken Accutane® (or products containing isotretinoin) in the last 12 months?	☐	☐
21.	Have you taken Tretinoin (like Retin-A®, Renova®) in the last 6 months?	☐	☐
22.	Have you had any unprotected sun exposure, used tanning creams (including sunless tanning lotions) or tanning beds or lamps in the last 4-6 weeks?	☐	☐

Signature: Date:

LAST FOUR OF SSN # _____

Allergan MEDICAL INSTITUTE
Advancing Excellence in Facial Aesthetics

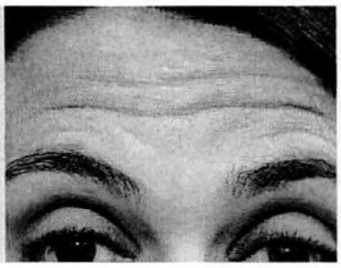
Patient Interest Questionnaire

Name: Age: Date: / /

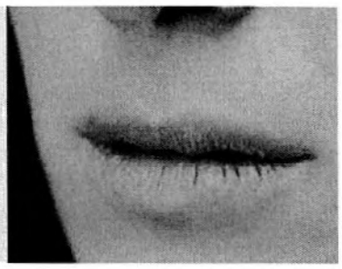
Please indicate any areas of concern for you

Check all that apply.

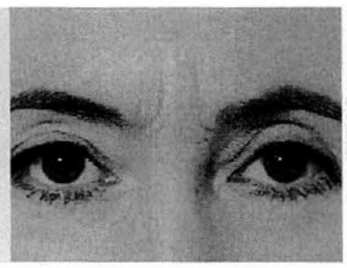
- ☐ Forehead lines



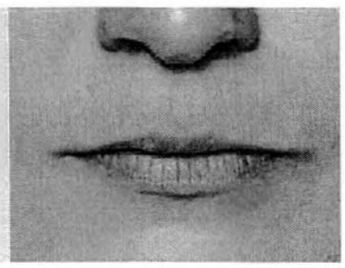
- ☐ Lip appearance and texture



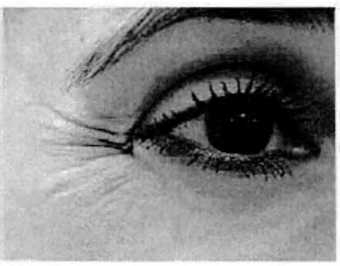
- ☐ Frown lines



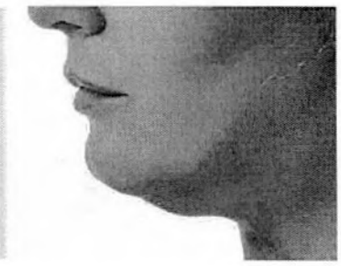
- ☐ Thin lips



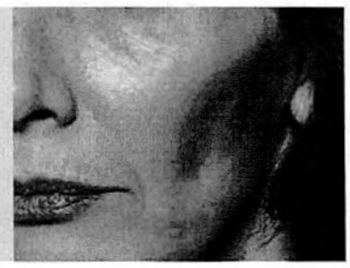
- ☐ Crow's feet lines



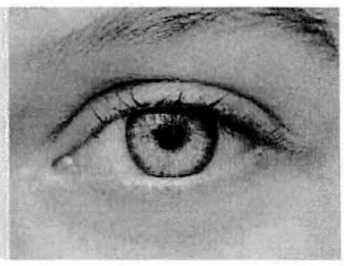
- ☐ Double chin



- ☐ Flattened cheeks/ sunken cheeks

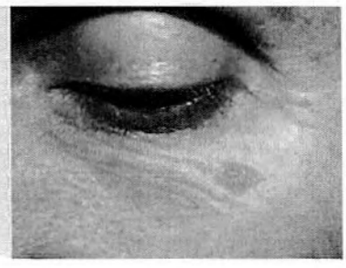


- ☐ Thinning or inadequate lashes



- ☐ Lines and wrinkles around the nose and mouth

- ☐ Skin appearance and texture



Be sure to bring this to your aesthetic specialist for your assessment.

Aesthetic specialist: See the next page to create the patient's treatment recommendations

MEDIA CONSENT FORM FOR ADULTS

I, ____, participate in programs and activities with **Dr. Padma's Aesthetics**.

I hereby consent to participation in interviews, the use of quotes and the taking of photographs and/or videos of me on behalf of **Dr. Padma's Aesthetics**. I also grant the right to edit, use, and reuse said products for promotional purposes, including in print, online, social media and all other forms of media. I consent to the use of my name and association with **Dr. Padma's Aesthetics** for the foregoing purposes. I give this authorization without expectations of compensation.

This consent will remain in effect until I revoke it in writing.

Signature: ____ Date: ____________________

= =

MEDIA CONSENT FORM FOR CHILDREN & YOUNG ADULTS

I, ____, am the parent/guardian of ____ (referred to as "my child"), and participate in programs and activities with (insert name of organization).

I hereby consent to my child's participation in interviews, the use of quotes and the taking of photographs and/or videos of him/her on behalf of **Dr. Padma's Aesthetics**. I also grant the right to edit, use, and reuse said products for promotional purposes, including in print, online, social media and all other forms of media. I consent to the use of my child's name and association with **Dr. Padma's Aesthetics** for the foregoing purposes. I give this authorization without expectations of compensation.

This consent will remain in effect until I revoke it in writing.

Signature: ____ Date: ____________________

Padma Sripada MD

Internal Medicine and Primary care

COVID-19 SCREENING QUESTIONNAIRE

Name: _____ DOB: _____

Patient name if different then person being screened: _____

1. Have you been feeling well overall? _____

2. Are you experiencing any of the following symptoms? ☐ Yes ☐ No

   - ☐ Cough
   - ☐ Sore throat
   - ☐ Congestion
   - ☐ Shortness of breath
   - ☐ New loss of taste or smell
   - ☐ Muscle Pain (different from your normal)
   - ☐ Shaking with chills
   - ☐ Headache (different from your normal)

   If yes to any of the above, for how long? _____

3. Do you have a fever? ☐ Yes ☐ No If yes, results: _____

4. Do you have any known exposure to anyone with a diagnosis of COVID-19? ☐ Yes ☐ No

5. Have you received COVID testing? ☐ Yes ☐ No If yes, results: _____ Date: _____

6. Have you traveled anywhere in the last 14 days? ☐ Yes ☐ No

   If yes where, and when? _____

We are currently under a no visitor advisement, so we ask that you come to your appointment by yourself and make sure to wear a mask.

Signature: _____ Date: _____

Prescreened via telephone

☐ Yes, By/When: _____ ☐ No, Left message: _____