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New Patient Questionnaire

Today's Date_____Name_____Date of Birth_____

Address_____City_____State____Zip_____

Home Phone_____Cell phone_____

E-Mail Address _____

Is it ok for us to contact you to check in by phone? **Y N** By postal mail? **Y N**
By email? **Y N** By text message? **Y N**

What is the best way for us to contact you to follow up and to thank you for your visit(s)? **Phone Email Text Postal Mail**

How did you hear about us?_____

- If you were referred by one of our patients, please let us know their name so that we may thank him or her.

Do you have any of the following conditions?

- ☐ Bleeding disorder
- ☐ Cancer
- ☐ HIV/AIDS
- ☐ Pregnancy
- ☐ Nursing
- ☐ Latex allergy
- ☐ Melasma
- ☐ Skin Sensitivity
- ☐ Active infection
- ☐ Rheumatic disease (Rheumatoid Arthritis; Lupus)
- ☐ Keloids
- ☐ Diabetes
- ☐ Organ transplant
- ☐ Frequent cold sores
- ☐ Vitiligo
- ☐ Multiple Allergies (food; environmental)

Are you currently taking any of the following medications/supplements?

- ☐ Ibuprofen/Naproxen
- ☐ Aspirin
- ☐ Warfarin (Coumadin)
- ☐ Fish oil
- ☐ Immunosuppressants
- ☐ Antibiotics
- ☐ Eliquis/Pradaxa/Xarelto
- ☐ Steroids (prednisone)
- ☐ Chemotherapy
- ☐ Retin-A

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Do you have any medication allergies? _____
Do you tan or spend significant amounts of time outdoors in the sun? **Y N**
Do you smoke tobacco products? **Y N**
Would you say that you "bruise easily"? **Y N**

Which (if any) of these statements apply to you?

- ☐ I would prefer a longer-lasting result (5-10 years) , even if it costs more
- ☐ I would prefer a longer-lasting result, even if it involves more recovery
- ☐ I would prefer a longer-lasting result, even if it is more invasive
- ☐ I would prefer minimal recovery, even if it means a more temporary result (6-12 months)
- ☐ I would prefer minimal recovery, even if it means more modest improvement

What would you like to **improve** about your skin/appearance?

- ☐ Brown Spots/Sun Damage
- ☐ Capillaries/Veins on face
- ☐ Drooping Mouth Corners
- ☐ Dark Circles Under Eyes
- ☐ Rough Skin Texture
- ☐ Lines and Wrinkles/Upper Face
- ☐ Lines and Wrinkles/Lower Face
- ☐ Loss of Lip Volume
- ☐ Loss of Cheek Volume
- ☐ Acne
- ☐ Acne Scars
- ☐ Loose Skin On Neck
- ☐ Jowls/Jawline laxity
- ☐ Deep Nasolabial Folds
- ☐ Smokers Lines
- ☐ Sun Damage on Neck/Chest
- ☐ Aging of Hands
- ☐ Sagging Eyelids
- ☐ Large Pores
- ☐ Loss of Brow Height
- ☐ Crepey Skin Under Eyes
- ☐ Unwanted Body Fat
- ☐ Loose skin on the body
- ☐ Cellulite

Which of these procedures do you think you may be interested in, now, or at some point in the future?

- ☐ Botox
- ☐ Laser Skin Rejuvenation
- ☐ Non-surgical threadlifting
- ☐ Chemical Peels
- ☐ Fillers
- ☐ IPL (Photofacial)
- ☐ Microdermabrasion
- ☐ Medical Facials

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- ☐ Microneedling
- ☐ Body Contouring/Liposuction
- ☐ J Plasma Total Facial Rejuvenation
- ☐ PRP (platelet-rich plasma)
- ☐ Body Skin Tightening
- ☐ Facial Fat Transfer

Body Dysmorphia Screening: *It is our ethical responsibility to encourage you to have a healthy relationship with your body. Aesthetic treatments are imperfect and cannot help you solve life's more complicated problems. These questions help us serve and protect you best.*

- Approximately how many times a day to you deliberately check on your appearance (in a mirror, a reflective surface, on your phone, etc.)? _____
- To what extent do you feel your features are ugly, unattractive, or "not right"? _____
- Does your appearance cause you distress? _____
- Does your appearance cause you to avoid certain situations? _____
- On a scale of 1 to 10, how preoccupied with your appearance are you? _____
- On a scale of 1 to 10, how much does your appearance define you as a person? _____

If you are interested in Body Contouring, what areas of your body are you interested in improving/contouring?

_____

Are you interested in learning more about prescription-grade anti-aging skin care products? **Y N**

Are you currently a member of the GALDERMA Aspire rewards program? **Y N**

We strive for the highest levels of customer satisfaction. If you have had any negative experiences at other centers, what were they? _____

_____

Is there anything else that you would like us to know that would help us assist you best today? _____

_____

Our Mission at Sonata is to bring beauty, love, light and compassion to our amazing patients.