

# Cosmetic Interest Questionnaire

Please complete the following form and return to the front desk so that we may best serve your needs.

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

YES \_\_\_ NO \_\_\_ I would like to be contacted for further information, events and promotions

**For the following statements, please check off the areas that interest you at this time:**

YES \_\_\_ NO \_\_\_ I would like to improve the condition and appearance of my skin.

YES \_\_\_ NO \_\_\_ When looking at my face in the mirror, I believe I look older than my true age.

YES \_\_\_ NO \_\_\_ I am interested in surgical procedures for body shaping and sculpting.

YES \_\_\_ NO \_\_\_ I am interested in non-surgical options to correct fine lines & wrinkles.

YES \_\_\_ NO \_\_\_ I am interested in rejuvenating my eyes.

YES \_\_\_ NO \_\_\_ I am interested in contouring and re-shaping my nose.

YES \_\_\_ NO \_\_\_ I am interested in full face rejuvenation.

YES \_\_\_ NO \_\_\_ I am interested in non-surgical procedures for body shaping and sculpting.

**Cosmetic concerns, procedures or products of interest to you (please check all that apply)**

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Wrinkles/Fine lines   | <input type="checkbox"/> Age/Brown spots | <input type="checkbox"/> Photofacial                       | <input type="checkbox"/> Excessive sweating  |
| <input type="checkbox"/> Crêpe skin under eyes | <input type="checkbox"/> Botox®/Dysport  | <input type="checkbox"/> Juvederm/Restylane                | <input type="checkbox"/> Brown spots         |
| <input type="checkbox"/> Acne/Acne scars       | <input type="checkbox"/> Skin tightening | <input type="checkbox"/> Using your own fat for volumizing |  |
| <input type="checkbox"/> Microdermabrasion     | <input type="checkbox"/> Crows Feet      | <input type="checkbox"/> Skin texture                      | <input type="checkbox"/> Décolletage (chest) |
| <input type="checkbox"/> Corrective skin care  | <input type="checkbox"/> Sun Damage      | <input type="checkbox"/> Neck/Chin/Jawline Contouring      |  |

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Marital Status \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ ZIP \_\_\_\_\_ E-Mail \_\_\_\_\_

Occupation \_\_\_\_\_

Home Telephone \_\_\_\_\_  may contact me  may leave a message

Office Telephone \_\_\_\_\_  may contact me  may leave a message

Mobile Telephone \_\_\_\_\_  may contact me  may leave a message

**Personal Goals**

I am here today to discuss: \_\_\_\_\_

My goals are to improve my appearance by: \_\_\_\_\_

I would describe the present condition I wish to improve as: \_\_\_\_\_

**Background**

I have heard about Dr. Shapiro through: \_\_\_\_\_

I have decided to consult with Dr. Shapiro because: \_\_\_\_\_

I have consulted with the following physicians, friends or family about my goals: \_\_\_\_\_

**I have the following skin conditions:**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Hyperpigmentation      | <input type="checkbox"/> Expression lines | <input type="checkbox"/> Sensitive skin                  |
| <input type="checkbox"/> Melasma                | <input type="checkbox"/> Acne             | <input type="checkbox"/> Irregular moles or skin growths |
| <input type="checkbox"/> Sun damage/brown spots | <input type="checkbox"/> Facial veins     | <input type="checkbox"/> Enlarged pores                  |
| <input type="checkbox"/> Facial wrinkles        | <input type="checkbox"/> Rosacea          |  |

I currently use the following skin care products: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Whom may we contact with regard to your medical conditions?

Primary Care Physician: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_

Whom may we contact in an emergency?

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Telephone: \_\_\_\_\_ Mobile: \_\_\_\_\_

Address: \_\_\_\_\_

Lifestyle and Personal History:

I presently smoke (electronic included)	Yes	No	I have smoked	Yes	No
I presently use tobacco products	Yes	No	I have used tobacco products	Yes	No
I use recreational drugs	Yes	No	I have used recreational drugs	Yes	No

My regular exercise routine (type and frequency): \_\_\_\_\_

I consume alcoholic beverages (amount and frequency): \_\_\_\_\_

I take the following vitamins/herbal supplements (type and dosage): \_\_\_\_\_

\_\_\_\_\_

Health history:

I regularly take the following prescription/over-the-counter medications (type and dosage): \_\_\_\_\_

\_\_\_\_\_

I presently take the following prescription/over-the-counter medications (type, dosage and purpose): \_\_\_\_\_

\_\_\_\_\_

I am allergic to the following medications: \_\_\_\_\_

I have the following additional allergies: \_\_\_\_\_

I have had a staph infection in the past: \_\_\_\_\_ If yes, please explain: \_\_\_\_\_

I am presently under a doctor's care for the following conditions: \_\_\_\_\_

I have the following medical conditions: \_\_\_\_\_

I would describe my present state of health as: \_\_\_\_\_

I have had the following treatments:

\_\_\_ Non-cosmetic surgery (list type and date) \_\_\_\_\_  
\_\_\_\_\_

\_\_\_ Aesthetic or cosmetic surgery (list type and date) \_\_\_\_\_  
\_\_\_\_\_

\_\_\_ Botox® or similar treatment (botulinum type/regions treated/frequency/date of last treatment) \_\_\_\_\_  
\_\_\_\_\_

\_\_\_ Injected or implanted fillers (filler type/regions treated/date of last treatment) \_\_\_\_\_  
\_\_\_\_\_

\_\_\_ Chemical peel (define the type of peel and concentration) \_\_\_\_\_

\_\_\_ Dermabrasion or dermaplaning (date of last treatment) \_\_\_\_\_

\_\_\_ Laser resurfacing (date/outcomes) \_\_\_\_\_

\_\_\_ Photorejuvenation (date/outcomes) \_\_\_\_\_

\_\_\_ Other energy-based treatments (i.e. Thermagge®) (date/outcomes) \_\_\_\_\_

I attest the above history is completed to the best of my knowledge and understand and accept that my failure to disclose any of the above information can adversely affect a prescribed course of treatment to meet my goals, my safety, or the outcome of any treatment I elect to undergo with Daniel I. Shapiro, MD, or any member of his staff, including the Paradise Valley Skin Clinic.

\_\_\_\_\_  
Patient signature

\_\_\_\_\_  
Date

Please check any of the following conditions that you now have (or have ever had):

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Asthma                                 | <input type="checkbox"/> High blood pressure      | <input type="checkbox"/> Nervous disorders                      |
| <input type="checkbox"/> Hay Fever                              | <input type="checkbox"/> Chest pain               | <input type="checkbox"/> Mental Illness                         |
| <input type="checkbox"/> Allergy Problems                       | <input type="checkbox"/> Heart attack             | <input type="checkbox"/> Depression                             |
| <input type="checkbox"/> Hives                                  | <input type="checkbox"/> Heart murmur             | <input type="checkbox"/> Shingles                               |
| <input type="checkbox"/> Allergy to <u>local</u><br>anesthetics | <input type="checkbox"/> Irregular heartbeat      | <input type="checkbox"/> Stroke                                 |
| <input type="checkbox"/> Allergy to latex                       | <input type="checkbox"/> Joint pains/arthritis    | <input type="checkbox"/> Faint easily                           |
| <input type="checkbox"/> Cancer                                 | <input type="checkbox"/> Thyroid problems         | <input type="checkbox"/> Glaucoma                               |
| <input type="checkbox"/> Skin cancer                            | <input type="checkbox"/> Kidney disease           | <input type="checkbox"/> Cataracts                              |
| <input type="checkbox"/> Sun poisoning                          | <input type="checkbox"/> Bowel disorder           | <input type="checkbox"/> Diabetes                               |
| <input type="checkbox"/> Cold sores/fever blisters              | <input type="checkbox"/> Stomach problems         | <input type="checkbox"/> Positive skin test for<br>tuberculosis |
| <input type="checkbox"/> Pacemaker                              | <input type="checkbox"/> Liver disease            | <input type="checkbox"/> Anemia                                 |
| <input type="checkbox"/> Mitral valve prolapse                  | <input type="checkbox"/> Hepatitis                | <input type="checkbox"/> Irregular periods                      |
| <input type="checkbox"/> Artificial heart valve                 | <input type="checkbox"/> Exposure to AIDS         | <input type="checkbox"/> Yeast infection                        |
| <input type="checkbox"/> Artificial joints                      | <input type="checkbox"/> Blood clot in leg        | <input type="checkbox"/> HIV/Positive HIV test                  |
| <input type="checkbox"/> Abnormal chest x-ray                   | <input type="checkbox"/> Blood clot in lung       | <input type="checkbox"/> Sexually transmitted disease           |
| <input type="checkbox"/> Seizures                               |   |   |
| <br>  |   |   |
| <input type="checkbox"/> Headaches                              | <input type="checkbox"/> Shortness of breath      | <input type="checkbox"/> Heartburn                              |
| <input type="checkbox"/> Sleep disorders                        | <input type="checkbox"/> Bruising easily          | <input type="checkbox"/> Difficulty urinating                   |
| <input type="checkbox"/> Vision Trouble                         | <input type="checkbox"/> Frequent nosebleeds      | <input type="checkbox"/> Keloids/excessive scarring             |
| <input type="checkbox"/> Hearing impairment                     | <input type="checkbox"/> Foot or ankle swelling   | <input type="checkbox"/> Sensitive Skin                         |
| <input type="checkbox"/> Sinus problems                         | <input type="checkbox"/> Leg cramps               |   |
| <input type="checkbox"/> Persistent cough                       | <input type="checkbox"/> Extreme weight loss/gain |   |

My last tetanus shot was: \_\_\_\_\_

I would describe my present state of health as: \_\_\_\_\_

Female Patients:

I AM / AM NOT now pregnant

I AM / AM Not now nursing

I have given birth to \_\_\_\_\_ children I have had \_\_\_\_\_ Cesarean deliveries

I take/use the following contraceptives or hormone replacement therapy \_\_\_\_\_

My last mammogram was on \_\_\_\_\_ and was reported to be: \_\_\_\_\_

I attest the above health history is completed to the best of my knowledge and understand and accept that my failure to disclose any medical condition can adversely affect my safety or the outcome of any treatment I elect to undergo with Daniel I. Shapiro, MD, or any member of his staff, including the Paradise Valley Skin Clinic.

I consent that the above information is not a substitute for diagnostic medical testing that may be required prior to any surgical or other treatment. I consent that the above information is strictly used for screening purposes to determine my overall health.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

**DANIEL I. SHAPIRO, MD, F.A.C.S.**  
**SHAPIRO AESTHETIC PLASTIC SURGERY AND SKIN KLINIC**

**PATIENT PRIVACY and CONSENT**  
**FOR PURPOSES OF TREATMENT,**  
**PAYMENT AND HEALTHCARE OPERATIONS**

I, \_\_\_\_\_, hereby consent to the use or disclosure of my protected health information by the practice of Daniel Shapiro, M.D., hereinafter referred to as ("Practice"), for the purposes of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me by the Practice may be conditioned upon my consent as evidenced by my signature on this document.

I understand that payment for procedures that are aesthetic or cosmetic in nature are my sole responsibility and will not be billed to any third party. I understand that payment for such procedures may be requested in advance of any treatment. I understand there are no warranties, implied or otherwise, to the outcomes any treatment or procedure.

I also understand that I have the right to request restrictions as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. The Practice is not required to agree to the restrictions that I may request. However, if the Practice agrees to the restrictions that I request, such restriction is binding on the Practice.

I have the right to revoke this consent, at any time, in writing, except to the extent that the Practice has taken action in reliance on this consent.

My "protected health information" means health information and my demographic information collected from me and created or received by: the Practice, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me.

I understand I have a right to review the Practice's *Notice of Privacy Practices*, which has been offered to me by the practice, prior to signing this document. The *Notice of Privacy Practices* describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations. This *Notice of Privacy Practices* also describes my rights and the practice's duties with respect to my protected health information. The *Notice of Privacy Practices* for the Practice is available at the offices of the Practice: 5410 N. Scottsdale Road Suite F-100 Paradise Valley, Arizona 85253.

Terms of the *Notice of Privacy Practices* may change. If changes are made, I may obtain a revised *Notice of Privacy Practices* by: calling the offices of the practice requesting a revised copy be sent in the mail, or by requesting one at the time of my next appointment.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient or Personal Representative

\_\_\_\_\_  
Description of Personal Representative's Authority

\_\_\_\_\_  
Signature of Practice Representative and Witness