Paul Rottler, M.D., F.A.C.S.
Medical Spa

Patient Name:_____Date:_____

Address:_____

City_____State_____Zip_____County_____

Phone #: _____Height: ____Weight: _____SS#_____

Date of Birth:_____Age:_____Sex: M F Marital Status: S M D W

Email:_____

Employer:_____ Occupation:_____

Who referred you to our office? _____Online Search ☐ Other ☐

Reason for your visit:_____

Nearest Relative:_____ Phone #:_____

Past Personal Medical History (Please check all that apply)

- ☐ Adrenal Insufficiency
- ☐ Anemia/Thalassemia
- ☐ Anxiety
- ☐ Arthritis_____
- ☐ Asthma
- ☐ Atrial Fibrillation(Irregular Heartbeat)
- ☐ Autoimmune Disease_____
- ☐ Bipolar Disorder
- ☐ Blood Clots
- ☐ BPH
- ☐ Cancer_____
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Deep Venous Thrombosis
- ☐ Depression
- ☐ Diabetes
- ☐ Easy Bruising
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Head Trauma
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia
- ☐ Lupus
- ☐ Lymphoma
- ☐ Malignant Hypertension
- ☐ Mental Health Hospitalization
- ☐ Metal Implants
- ☐ Neuromuscular Disorder
- ☐ Paralysis
- ☐ Pneumothorax
- ☐ Prostate Cancer
- ☐ Pulmonary Embolism
- ☐ Radiation Treatment
- ☐ Renal Disorder
- ☐ Seizure Disorder
- ☐ Severe Reaction to Anesthesia
- ☐ Stroke
- ☐ Trauma
- ☐ Thyroid Disorder_____
- ☐ Valvular Heart Disease
- ☐ Vision Loss
- ☐ None
- ☐ Other_____ _____

Past Personal Skin History (Please check all that apply)

- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburn
- ☐ Eczema
- ☐ Keloid Scars
- ☐ Melanoma
- ☐ Pigment Disorder
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Serious Skin Infection
- ☐ Shingles
- ☐ Skin Lesions
- ☐ Squamous Cell Skin Cancer

Do you tan in tanning salon? Y ◯ N ◯

Do you use sunscreen? Y ◯ N ◯ If yes, SPF? ___

Have you taken Accutane in the last 6 months? Y ◯ N ◯

Topical Medications:

- ☐ RetinaA
- ☐ Renova
- ☐ Refissa
- ☐ Differin Gel
- ☐ Tazorac
- ☐ Other_____

Patient Social History:

Use of alcohol: never
Use of tobacco: never packs/day__
Use of drugs: never Type/Frequency_____

Do you currently have any of the following:

- ☐ Good general health
- ☐ Recent weight change
- ☐ Wears glasses/contact lens
- ☐ Earaches
- ☐ Chronic sinus problems
- ☐ Mouth Sores
- ☐ Nose bleeds
- ☐ Sore throat
- ☐ Swollen glands in neck
- ☐ Cough
- ☐ Bloody Sputum
- ☐ Asthma/wheezing
- ☐ Chest pain
- ☐ Palpitations
- ☐ Shortness of breath
- ☐ Swelling of feet/ankles
- ☐ Nausea/vomiting
- ☐ Diarrhea/ constipation
- ☐ Frequent heartburn
- ☐ Frequent urination
- ☐ Painful urination
- ☐ Bloody urine
- ☐ Joint aches/pains
- ☐ Joint stiffness/swelling
- ☐ Muscle pain/cramps
- ☐ Rash
- ☐ Change in skin color
- ☐ Varicose veins
- ☐ Breast pain or lumps
- ☐ Frequent headaches
- ☐ Numbness/tingling
- ☐ Paralysis
- ☐ Anxiety
- ☐ Depression
- ☐ Nervousness
- ☐ Insomnia
- ☐ Admitted to psychiatric facility in the past
- ☐ Difficulty with body image
- ☐ Anorexia
- ☐ Bulimia
- ☐ Problems with healing
- ☐ Problems with scarring (hypertrophic or keloid

Prescription/OTC Medications:_____

_____

DrugAllergies:_____

_____

Latex Allergy? no

Are you pregnant? no

Are you nursing? no

Previous Surgeries:_____

_____

_____

Appointment & Cancellation Policy

A 24 hour notice is REQUIRED for any rescheduling or cancellation of your appointment. If you fail to provide us with 24-hour notice or "No-Show", a $75 fee will be charged to your account.

By signing below, I acknowledge and agree to these terms.

_____

Patient Signature

Electronic Correspondence

I give permission to Dr. Rottler and staff to email and/or text me information and/or photos pertaining to my care. Information that may be sent can include appointment dates and times, documents related to scheduling and answers to simple questions. I understand that these messages will be sent through unsecured servers and therefore may be at risk of security breach.

_____

Patient Signature

Before and After Photos

I am authorizing the Rottler Med Spa staff to take before and after pictures of the procedure(s) that will be performed on me. I understand that these pictures will only be used to determine optimum outcome of my service and/or treatment. They will not be displayed for any reason.

_____

Patient Signature

Services

We are trying to educate all of our patients about the different services we offer in our office. Please take a moment to let us know what interests you:

- ☐ Botox (Correction of lines and wrinkles)
- ☐ Juvederm/Voluma/Vollure (Filler for mid face, cheeks, and lips)
- ☐ Restylane/Volbella (Filler for superficial lines and lips)
- ☐ Kybella (Eliminates double chin)
- ☐ Skin Treatments (dermaplaning, microneedling, facials)
- ☐ Microdermabrasions/Chemical Peels (Deep Exfoliation)
- ☐ Laser Skin Rejuvenation (Improves fine lines, wrinkles, sun damage, tone, and texture)
- ☐ Skin Care Products
- ☐ Laser Hair Removal
- ☐ Latisse (Eyelash Enhancement)
- ☐ EMsculpt
- ☐ Exilis

Referral Rewards Program

If someone lists you as his or her referral source and they undergo a medical spa treatment, you will receive a 10% discount on your next treatment as our THANK YOU!