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### CONSULTATION QUESTIONNAIRE

NAME *(please print)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TELEPHONE *(home)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (*cell*) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (*work*) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wear contact lenses? Y N

Do you have a history of glaucoma? Y N

Do you have a history of diabetes? Y N

Any visual disturbances? Y N If yes, please describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use any of the following: Cortisone Y N If yes, when and how long\_\_\_\_\_\_\_\_\_\_\_

 Steroids Y N If yes, when and how long\_\_\_\_\_\_\_\_\_\_\_

Aspirin Y N If yes, when and how long\_\_\_\_\_\_\_\_\_\_\_

NSAID’s Y N If yes, when and how long\_\_\_\_\_\_\_\_\_\_\_

Coumadin Y N If yes, when and how long\_\_\_\_\_\_\_\_\_\_\_

Blood Thinners Y N If yes, when and how long\_\_\_\_\_\_\_\_\_\_\_

Are you on any other type of medication? Y N If yes, please list *(include herbals/vitamins)*

Are you allergic to any foods or medications? Y N If yes, please list *(include environmental)*

Have you ever had a reaction to cosmetics? Y N If yes, please list\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you allergic to any topical anesthetics? Y N If yes, please list\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any surgery around the eyes or mouth? Y N If yes, when and where\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are you planning any surgery or peels
 around the eyes or mouth? Y N If yes, when and where\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you get or have you ever had cold or
 canker sores, herpes simplex I ? Y N

Do you have any chronic illnesses? Y N If yes, please describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you presently use any Retin-A, Renova,
 Tretinoin, other retinols? Y N If yes, what product/strength/how long?

Have you ever had perm. cosmetics before? Y N If yes, where and how long ago\_\_\_\_\_\_\_\_\_

### Areas of Treatment

**Eyebrows\_\_\_\_ Upper Eyeliner\_\_\_\_ Lower Eyeliner\_\_\_\_ Lip Liner\_\_\_\_ Lip Shading\_\_\_\_**

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

 Patient Identification type / #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Technician Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Technician Printed Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_