

## New Patient Enrollment Form



**GULJEET  
SOHAL, M.D.**

**Balle Bliss  
Luxury  
Medical  
Spa**

13611  
Skinner Rd  
Suite 270

Cypress, TX  
77429

Phone:  
281-758-2777

Fax:  
281-758-2843

The following information is to be completed by the patient, or the patient's legally authorized representative/parent:

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
(Last, First, Middle)

Patient DOB: \_\_\_\_\_ SSN: \_\_\_\_\_ Gender: \_\_\_\_\_

Home:

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_

Cell#: \_\_\_\_\_ Home#: \_\_\_\_\_

Employment:

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

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_

Office#: \_\_\_\_\_ Secretary#: \_\_\_\_\_

Insurance: \_\_\_\_\_ Occupation: \_\_\_\_\_

**How did you hear about us?** \_\_\_\_\_

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**Have you ever had the following?**

**YES**

**NO**

• Current or history of cancer, especially malignant melanoma or recurrent non-melanoma skin cancer, or pre-cancerous lesions such as multiple dysplastic nevi.		
• Any active infection.		
• Diseases which may be stimulated by light at 515 nm to 1200 nm, such as history of recurrent Herpes Simplex, Systemic Lupus Erythematosus, or Porphyria.		
• Use of photosensitive medication and/or herbs that may cause sensitivity to 515 - 1200 nm light exposure, such as Isotretinoin, tetracycline, or St. John's Wort.		
• Immunosuppressive diseases, including AIDS and HIV infection, or use of immunosuppressive medications.		
• Patient history of Hormonal or endocrine disorders, such as polycystic ovary syndrome or diabetes, unless under control.		
• History of bleeding coagulopathies, or use of anticoagulants.		
• History of keloid scarring.		
• Exposure to sun or artificial tanning during the 3-4 weeks prior to treatment.		
Have you ever seen a dermatologist for your skin?		
Are you pregnant or lactating?		
Have you had any skin acid peels?		
Have you ever had a microdermabrasion?		
Have you ever had dermal fillers (Juvederm, Radiesse, Restylane)?		
Have you ever had a skin allergy?		
Do you have any known drug allergies?		
Do you smoke?		
Do you consume alcohol?		
Do you have a regular diet?		
Do you exercise?		
Do you take vitamins?		
<b>Do you now, or at any time in the past, get cold sores or herpes?</b>		
<b>Do you, or any member of your family, have/had skin cancer?</b>		
<b>If yes, Relationship? _____</b>		

When was your last menstrual period? \_\_\_\_\_

**Have you EVER used ACCUTANE (When)?** \_\_\_\_\_

What topical medications do you use?

Retin-A or Retinol

Glycolic

Lactic

Other: \_\_\_\_\_

What medications do you currently use?

Antibiotics

Birth Control

Other, please explain:

Hormones

Diuretics

\_\_\_\_\_

Do you suffer from any medical problems? \_\_\_\_\_

**What type of skin care products are you using now:** \_\_\_\_\_

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**FITZPATRICK CLASSIFICATION SYSTEM: (Please mark skin type below which best describes you)**

SKIN TYPE	SKIN COLOR	CHARACTERISTICS
I	WHITE	Always burns, never tans
II	WHITE	Usually burns, tans less than average
III	WHITE	Sometimes mild burn, tans about average
IV	WHITE	Rarely burns, tans more than average
V	BROWN	Rarely burns, tans profusely
VI	BLACK	Never burns, deeply pigmented

**Health issues and procedures or products of interest to you (please check all that apply).**

- |   |  |
|---|--|
| <input type="checkbox"/> Fine Lines and Wrinkles                | <input type="checkbox"/> PhotoFacial                         |
| <input type="checkbox"/> Botox® Cosmetic                        | <input type="checkbox"/> Excessive Sweating of the Underarms |
| <input type="checkbox"/> Dermal Fillers                         | <input type="checkbox"/> Lines between nose and mouth        |
| <input type="checkbox"/> Restylane, Juvederm, Perlane, Radiesse | <input type="checkbox"/> Lip Enhancement                     |
| <input type="checkbox"/> Skin Rejuvenation                      | <input type="checkbox"/> Vertical Lips Lines (smokers lines) |
| <input type="checkbox"/> Uneven Skin Tone / “Splotchy” Skin     | <input type="checkbox"/> Liver Spots/Age Spots               |
| <input type="checkbox"/> Removing Facial Veins                  | <input type="checkbox"/> Removing Leg Veins                  |
| <input type="checkbox"/> Acne/Rosacea                           | <input type="checkbox"/> Wrinkle Prevention                  |
| <input type="checkbox"/> Spider Vein Treatment                  | <input type="checkbox"/> Hair Removal                        |
| <input type="checkbox"/> Tattoo Removal                         | <input type="checkbox"/> Crow’s Feet/Laugh Lines             |
| <input type="checkbox"/> Mineral Make Up                        | <input type="checkbox"/> Removing Skin Tags                  |

**Please answer the following questions on a scale of 1 to 5 by circling the appropriate number.**

When looking at my face in the mirror, I believe I look younger, the same as, or older than my true age.

Younger Than	True Age			Older Than
1	2	3	4	5

When looking in the mirror, I am Not, Somewhat, or Very concerned about the appearance of my wrinkles.

Not Concerned	Somewhat Concerned			Very Concerned
1	2	3	4	5

**What are your expectations/what would you like to accomplish from your relationship with Balle Bliss?**

\_\_\_\_\_

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**Skin Test Questionnaire**



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(Last, First, Middle)

Date: \_\_\_\_\_

**Answer these questions to find out how your sun habits and lifestyle have aged your skin.**

**AGE**

1. How old are you? (Enter that number) \_\_\_\_\_ → = \_\_\_\_\_
2. Do you have any permanent facial brown spots or broken blood vessels?
  - (If yes, add 2) +/- \_\_\_\_\_
3. Do you have deep creases on your forehead or cheeks?
  - (If yes, add 5) +/- \_\_\_\_\_
4. Are there noticeable lines around your eyes and/or lips?
  - (If yes, add 3) +/- \_\_\_\_\_
5. Did you or do you still tan-indoors or outdoors at least twice a week?
  - (If yes without sunscreen, add 10) (If yes with sunscreen, add 5) +/- \_\_\_\_\_
6. Has your face suffered at least 3 severe sunburns, complete with peeling?
  - (If yes, add 5) +/- \_\_\_\_\_
7. Do you smoke?
  - (If yes, add 3) +/- \_\_\_\_\_
8. Do you drink five or more beers, glasses of wine or cocktails a week?
  - (If yes, add 2) +/- \_\_\_\_\_
9. Do you work out at least three times a week?
  - (If yes, subtract 1) +/- \_\_\_\_\_
10. Do you munch on fruits and vegetables three or more times a day?
  - (If yes, subtract 1) +/- \_\_\_\_\_
11. Do you use an SPF 30+ product each morning?
  - (If yes, subtract 4) +/- \_\_\_\_\_
12. Do you use antioxidants as a part of your daily routine? (Vitamin C, etc.)
  - (If yes, subtract 2) +/- \_\_\_\_\_
13. Do you use prescription lotions (such as tretinoin or hydroquinone)?
  - (If yes, subtract 2, if both, subtract 5) +/- \_\_\_\_\_

**Enter the Total here. This is your skin's age.** = \_\_\_\_\_