Registration & Aesthetic Questionnaire

Non-Surgical Procedures

Name: _____ Date: _____

Address: _____

City: _____ Postal Code: _____

Home Phone #: _____ Cell #: _____ Work #: _____

E-Mail Address: _____ Newsletter: YES / NO

How did you hear about us? _____

Sex: M / F Age: _____ Date of Birth: _____

Health Card #: _____ Version Code: _____

Family Doctor: _____ Phone #: _____

Emergency Contact: _____ Phone #: _____

Emergency Contact Relationship: _____ Are you a Canadian Citizen? YES / NO

What is your main reason for you visit?

_____

_____

_____

I would like to be advised on (please circle):

- How I can look better for my age
- How I can change something that has been bothering me for years
- How I can look more attractive
- Other: _____

Which of these statements best reflect how you would like to look and feel after the treatment? Please circle all that apply.

- I want to look less tired
- I want to look less angry
- I want to look less sad

- I want a less saggy appearance
- I want to look more youthful
- I want to look more attractive
- I want my face to look slimmer
- I want softer features

How would you rate the quality of your skin?

- Poor
- Fair
- Good
- Very Good
- Excellent

If you could enhance an aspect of your skin, what would you enhance?

- Hydration
- Elasticity
- Smoothness
- Color

Please circle the treatments that interest you:

SKIN ENHANCEMENT	FACIAL IMPROVEMENT	OTHER
Blu-U Acne Treatment	Wrinkle Relaxers	Laser Hair Removal
Skin Care Products	Fillers	Scar Removal
Laser Resurfacing	Botox/Dysport	Coolsculpting
Skin Tightening	SoftLift	Hair Replacement/Restoration
Chemical Peels	Double Chin Reduction (Belkyra)	Fat Reduction Treatments
Spectra Hollywood Peel	PRP – Vampire Facial	ThermiVa – Vaginal tightening
Microneedling	Radio Frequency treatment	Tattoo Removal

All purchases of non-surgical products and services are non-refundable. A credit may be applied to future product or service purchases.

Medical History

Patient Name:

Date of Birth:

Please indicate all medications you are currently taking and/or taken in the past 6 months:

_____

Please list all vitamin supplements you are currently taking:

_____

Please list any allergies:

_____

Circle any of the following medical conditions you have or have had in the past:

- Sensitivity allergy to Lidocaine or Collagen
- Auto Immune Disease (i.e. Lupus)
- History of Cold Sores or Shingles
- Cardiac Problems (i.e. pacemaker or defibrillator)
- Drug Addiction or Alcoholism
- Epilepsy
- Scars/Keloids
- Bleeding Disorders or Blood clots
- Hepatitis
- Melasma/ Post-Inflammatory Hyperpigmentation

Please list any other medical conditions not listed above that you currently have or have had in the past:

_____

_____

Medications that cause bleeding: Do you take any of the following on a regular basis?

- Aspirin or Aspirin containing medications
- Ibuprofen (Motrin, Advil)
- Ketoprofen (Aleve)
- Vitamin E (excluding that in a multivitamin)
- Anti-Inflammatories or Muscle Relaxants

Are you currently a smoker (Nicotine-containing products)? Yes / No

Have you been on Accutane (acne medication) in the last 6 months? Yes / No

Any previous hospitalizations or operations? No / Yes: _____

Have you had Plastic Surgery or other Surgery? No / Yes: _____

Have you had any Cosmetic Injections (Botox, Dysport, Fillers) before: No / Yes (If yes, please indicate the date of your last treatment:

_____

Have you had any Laser procedures before? No / Yes (If yes, please indicate what laser treatment and how long ago):

_____

Patient Signature: Date:

Witness Signature: