Clinic 5 Laser

460 6th Street
Courtenay, BC V9N 1M3

New Patient Intake Form

Date: _____

Name: First _____ **Last** _____ **DOB** _____

Occupation: _____

Address: _____ **City** _____ **Postal Code** _____

Phone: Home #: _____ **Cell #:** _____ *Please indicate preferred #.*

Email: _____ *May we add you to our mailing list?* ***Yes*** _____ ***No*** _____

Primary Care Doctor: _____ **Phone #:** _____

Emergency Contact: _____ **Phone #:** _____

How did you hear about us?

_____

Current Medications:

_____

Allergies:

_____

Medical History: *Please circle all items that apply.*

Diabetes	Cancer	Seizures/Epilepsy	Auto-Immune Disorders. Currently on Steroids
Multiple Sclerosis	Heart conditions Pacemaker	Arthritis	Active infections or History of MRSA or Staph infections
Bleeding Disorder Currently on blood thinner	Hepatitis	History of Herpes infection, cold sores or fever blisters	HIV/AIDS

Skin Procedure History:

Have you ever had any of these procedures or treatments before? *Please circle all items that apply.*

Microdermabrasion Dermaplaning Waxing Other: _____

Chemical Peels Injections Fillers Phototherapy Laser Hair Removal Laser resurfacing

Have you seen a Dermatologist for your current skin care concerns? If so, whom:

_____

Personal Skin Care Assessment:

What is your race/ethnicity? _____

Hormone Assessment:

- Are you pregnant or trying to get pregnant? **YES** ___ If pregnant, how many weeks? _____ **NO** ___
- Are you currently breast feeding? **YES** ___ **NO** ___

- Are you taking fertility medications? **YES ___ NO ___**
- *Has a Doctor **ever prescribed** **Accutane, Retin-A, Renova or antibiotics for your acne? YES ___ NO ___***
- *Are you **currently taking** any of the above medications? **YES ___ List them:***
  _____
  _____
  *or **NO ___***

General Assessment:

- Do you bruise easily? **YES ___ NO ___**
- Do you scar easily? **YES ___ NO ___**
- Do you smoke? **YES ___ NO ___**
- Do you drink alcohol? **YES ___ NO ___**
- Do you use self-tanners (creams, spray-on tanners) or visit a tanning booth? **YES ___ NO ___**
- *If **YES,** how often? _____*
- *When was the last time you were at a tanning booth and/or applied self-tanner?*
  _____
- *When was the last time you waxed or used an epilator on areas to be treated?*
  _____

How would you describe your skin? *Please check the one you think applies at this time, remembering that skin type is ever changing.*

□ Oily: larger pores, always oily or shiny.
□ Combo oily: medium ores, oily T-zone, oil with dry perimeter.
□ Dry: small pores, flaky, tight, sallow skin.
□ Sensitive: frequent redness, sun sensitive, product sensitive.
□ Mature skin: loss of elasticity, hormonally dry and oily variance, fine lines and wrinkles.

Our Commitment to You:

To ensure your treatments are best suited to you, we ask that the information you provide us, to be as accurate and complete as possible. Following your treatment today, you will continue to play an important role in caring for your skin. For the best outcomes and recovery, we ask that you please follow our recommendations, after your treatments. At times we may suggest certain products or complimentary services. Should you have any questions, please do not hesitate to ask. We will be glad to help you meet your skin care needs today and into the future.

_____
_____
Signature of Patient or Responsible Party Date

_____
Print Name of Patient or Responsible Party

_____
_____
Signature of Provider Date

Provider Notes:

_____

_____