Edmonton Dermatology™ Cosmetic Centre

Client Intake Form

Legal First & Last Name: _____ Preferred Name: _____

DOB (m/d/y): _____ Gender: _____

Address: _____ City: _____

Province: _____ Postal Code: _____

Best Contact Number: _____ Alternate Phone Number: _____

Email: _____*How did you hear about us: _____

Emergency Contact: _____PH:_____ Relationship: _____

Alberta Health Care Number: _____

Are you currently under the care of a physician? ☐ No ☐ Yes: _____

What brings you in today? _____

Skin History

☐**Acne/Acne Scarring**	☐**Unwanted Hair**	☐**Skin laxity**
☐**Brown Spots/Sun Damage**	☐**Pigmented Lesions**	☐**Skin Texture/Scars**
☐**Spider Veins**	☐**Rosacea**	☐**Flushing of the skin**
☐**Fine Lines and Wrinkles**	☐ **Melasma**	☐**Crows Feet**
☐**Dry Skin**	☐**Large Pores**	☐**Deep Lines/Shadows**

Are you currently taking/using any of the following for your skin condition?

☐ Hydroquinone or bleaching agent ☐ Accutane ☐ Retin-A

Do you form thick or raised scars (keloid)? ☐ Yes ☐ No

Do you develop hyperpigmentation? ☐ Yes ☐ No

Are you planning a vacation in the sun in the next 3 months? ☐ Yes ☐ No

When were you last exposed to extensive sun light or a tanning booth? _____

Do you require information on sun screen/skin cancer prevention? ☐ Yes ☐ No

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MEDICAL HISTORY

Do you have any of the following conditions?

☐ Arthritis	☐ Chest Pain	☐ HIV/AIDS
☐ Any active infection	☐ Epilepsy or seizures	☐ Neurologic disorder
☐ Bleeding disorders	☐ Heart Disease	☐ Sensitive teeth
☐ Bruising	☐ Hepatitis	☐ Moles
☐ Dark spots from pregnancy	☐ Herpes Simplex (Cold Sores)	☐ Skin injury
☐ Diabetes	☐ High blood pressure	☐ Vision deficits
☐ Cancer _____	☐ Hormone imbalance	☐ Thyroid disease

☐ Other: _____

DO YOU TAKE ANY OF THE FOLLOWING?

☐Insulin	☐Appetite suppressants	☐ Thyroid medication
☐ Sedatives	☐ Aspirin or Ibuprofen	☐ Hormone/contraceptives
☐ Blood thinners	☐ Cortisone or steroids	☐ Anti-Depressants

☐ Antibiotics ***PLEASE LIST NAMES OF ALL MEDICATIONS:_____

_____

_____

For female patients: Are you pregnant/breastfeeding? ☐ Yes ☐ No

DO YOU HAVE ALLERGIES TO ANY OF THE FOLLOWING?

☐ Topical skin care products ☐Anesthesia ☐Latex ☐ Food ☐Plants ☐Medications

☐Other: _____

I have answered the questions contained in this questionnaire to the best of my knowledge.

I understand it is my responsibility to inform my practitioner of my current health conditions while seeking treatment as a patient. I will update this information as it occurs if there are changes to my health in between treatments.

Signature: _____ **Date: _____**