

GENERAL INFORMATION

Name – First:	Middle:	Last:	
Birthdate – Month: Day:	Year:	Gender:	
Preferred pronouns: 🗆 she/her 🗆 he	e/him □they/them □other (pl	ease specify):	
Address:	City:	Province/State:	
Postal Code/ Zip Code:	Occupation:		
Family doctor:	Personal Health Number (PHN):	
Phone – Home:	Work:	Cell:	
Permission to leave phone message: \Box home \Box work \Box cell \Box please do not leave messages			
Email – Personal:	Work:		
Permission to contact me via email: 🗌 personal 🗍 work 🗋 please do not email me			
Preferred method of contact: Cell phone home phone work phone email text			
View Laser Skin Rejuvenation Newsletter: please subscribe me no thank you <i>Our monthly email newsletter includes clinic news, event details, patient stories, and promotions exclusive to</i> <i>newsletter recipients. We will never share your contact information.</i>			
How did you hear about us? doctor	referral 🗌 our sign 🗌 event	□internet search □social media	
☐ friend referral - friend's name:	May we	e thank your friend? □yes □no	

Martin Ray, MD View Laser Skin Rejuvenation • 1443 View Crescent Delta, B.C. V4L 2K2 Phone (604) 943-9399 • Fax (604) 943-8344



MEDICAL HISTORY

Height:	Weight:	Do you smoke? ∏yes ∏no	
If you consume alcohol, approximately how many drinks do you have per week?			
Are you: pregnant breastfeeding planning to get pregnant			
Please check off any condition for which you have previously been treated:			
□arthritis □autoimmune disord	ler \Box blood disorder \Box cancer \Box] cold sores \Box diabetes \Box epilepsy	
heart disease hormonal imbalance hypertension keloid scars kidney disease melanoma			
□menopause □MRSA □psoriasis □shingles □skin pigmentation □thyroid disorder			
other (please specify):			
Allergies:			
Past illnesses:			
Past surgeries:			
Current medications:			

AESTHETIC HISTORY

Have you had a consultation for a cosmetic procedure before? \Box yes \Box no



Please list the details of your past aesthetic treatments:

1)	Treatment:	Provider:	Date:
2)	Treatment:	Provider:	Date:
3)	Treatment:	Provider:	Date:
4)	Treatment:	Provider:	Date:
5)	Treatment:	Provider:	Date:

If you run out of space, please add other treatments, providers, and dates to the blank side of the page.

AESTHETIC INTERESTS

How often do you think about wanting a cosmetic procedure? \Box most days \Box weekly \Box monthly \Box rarely		
How would you like to look? (please check all that apply) \Box less tired \Box less angry \Box less sad		
□less saggy □contoured □younger □attractive □feminine □masculine		
Is there a special event in the future where you would like to look your best? \square yes \square no		
If so, when is it? (date)		

SKIN CARE

How would you rate the quality of your skin? $\square_{poor} \square_{fair} \square_{good} \square_{very good} \square_{excellent}$			
If you could improve an aspect of your skin, what would it be? \Box hydration \Box thickness \Box elasticity			
□ _{colour} □ _{sensitivity} □ _{smoothness} □ _{redness} □ _{brown spots} □ _{breakouts}			
Current makeup (brands/products):			
Current skin care (brands/products):			
Current sunscreen (brand/spf):			



Are you currently using: \Box retinol \Box vitamin c serum	$\Box_{ m growth}$ factors	\Box skin lightening	\Box glycolic acid
🗆 salicylic acid 🔲 cleanser 🔲 soap			

CONDITIONS AND AREAS YOU WOULD LIKE TO DISCUSS

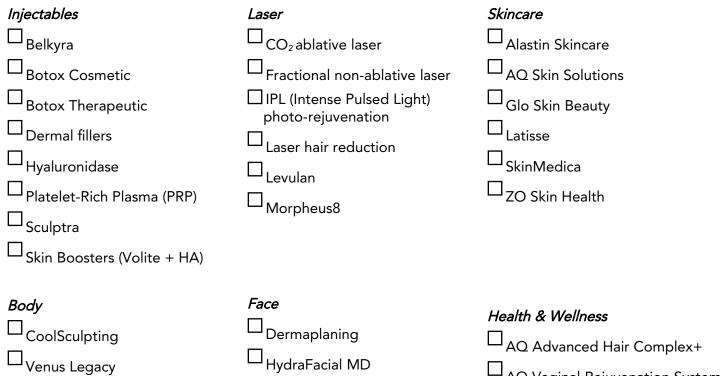
Cosmetic - please check all that apply:

acne scars	□ _{jowls}	□ _{redness} & rosacea	
body shape	□ lip lines	□ _{sensitive} skin	
Cheeks	\Box lip shape and volume	□ _{scars}	
Chin	🗆 _{masseter} size	□ _{skin colour}	
□ _{crow's feet}	\Box marionette lines	□ _{skin tone}	
double chin (submental fullness)	□ _{melasma}	□ _{skin texture}	
eyebrows	□ _{mid face}	\Box_{sun} damage/sun spots	
eyelashes	□ _{nasal} folds	□ _{sunken eyes}	
□ facial aging	□ _{neck fat}	$\Box_{\text{tear troughs}}$	
☐ facial volume loss	□ _{neck lines}	□ _{temples}	
□ fine lines & wrinkles	□ _{neck pain}	$\Box_{unwanted hair}$	
flushing	□ neck skin	$\Box_{ m other}$ (please specify):	
forehead			
hair loss	□ _{pigment}		
□ _{jawline}	\Box_{red} vessels		
Therapeutic – please check all that apply:			
□ _{acne} □ _{excessiv}	e sweating (hyperhidrosis)	□ _{migraines}	
Bell's Palsy	(including temporomandibular	□ _{vertigo}	
	orders, or TMJ)	other (please specify):	



TREATMENTS YOU ARE INTERESTED IN

Please check all that apply:



________Lymphatic drainage

AQ Vaginal Rejuvenation System

□_{Nitric Oxide} (N1O1)