VIEW LASER SKIN REJUVENATION

Martin Ray MD MCFP (SEM)

Date:_____

NAME First:_____ **Middle** _____ **Last :**_____

Birth date (month) _____ **(day)**_____**(year)**_____ ☐**Male** ☐ **Female** ☐_____

Family Doctor:_____ **Medical Care Card #:**_____

Address: _____ **City:** _____

Province/State:_____ **Postal Code/ Zip Code:** _____ **Occupation:** _____

Phone

☐ home_____ ☐work_____☐ cell_____

Permission to leave phone message: ☐ home ☐ work ☐ cell ☐ please do not leave phone messages

Email

☐ home _____ ☐ office_____

☐ I give permission for View Laser to contact me via email ☐ please do not email me

Preferred method of contact

☐ cell phone ☐ home phone ☐ work phone ☐ email ☐ text

How did you hear about us?

☐ doctor referral ☐ internet search ☐ yellow pages ☐ newspaper ad ☐ brochure mail out

☐ fundraising event ☐ our sign ☐ I'm a patient of View Medical ☐ Facebook ☐ Instagram ☐real self

☐ friend (may we thank them for referring you?) Friend's *name:* _____

AESTHETIC INTERESTS

How often do you think about wanting a cosmetic procedure? ☐ most days ☐ weekly ☐ monthly

Which statements best reflect after a treatment how you would like to feel and look?

☐ less tired ☐ less angry ☐ less sad ☐ less saggy ☐ slimmer

☐ younger ☐ attractive ☐ more feminine ☐ more masculine

Is there a special event in the future where you would like to look your best? ☐ yes ☐ no

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MEDICAL HISTORY

Check appropriate box next to any condition for which you have been treated:

□ shingles □ cold sore s □ MRSA □ keloid scars □ autoimmune disorder □ arthritis □ psoriasis

□ skin pigmentation □ melanoma □ cancer □ epilepsy □ hormonal imbalance □ diabetes □ kidney disease
□hypertension □ heart disease □ steroid or hormonal therapy □ blood disorders □ menopause

□ thyroid disorder

□ Other:_____

Are you □ pregnant □ breast feeding □ hoping to get pregnant

Height: _____ Weight:_____ Do you smoke □ yes □ no # per day? ____

Allergies (please list): _____

Past illnesses: _____

Past surgeries: _____

Current medications: _____

PAST AESTHETIC HISTORY

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

Please check treatments you have received previously:

□ cosmetic Botox □ therapeutic Botox □ dermal fillers □ permanent filler □ Accutane □ facials
□ microdermabrasion □ hydra facial □ chemical peels □ Levulan □ Latisse □ laser hair reduction
□ non-ablative laser □ CO_2 ablative laser □ IPL (photofacial) □ Coolsculpting □ Belkyra □ liposuction
□ nose surgery □ cosmetic surgery

Recent treatments

1) date_____ treatment _____ by_____

2) date_____ treatment _____ by_____

3) date_____ treatment_____ by_____--

SKIN CARE

Current makeup_____

Current sunscreen _____

Current skin care products: _____

Are you using: □ retinol □ vitamin c serum □ growth factors □ skin lightening □ glycolic

How would you rate the quality of your skin? □ poor □ fair □ good □ very good □ excellent

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Skin care (cont'd)

If you could improve an aspect of your skin, what would that be?

□ hydration □ thickness □ elasticity □sensitivity □ smoothness □ color □redness □brown spots

□ break outs

CONDITIONS I WOULD LIKE TO DISCUSS

□ sad appearance □ tired appearance □ angry appearance □ facial sagging □ facial aging
□ fine lines & wrinkles □ forehead □ eye brows □ sunken eyes □ tear troughs □ temples □ cheeks
□ mid face □ nose □ nasal folds □ marionette lines □ lip lines □ lip shape and volume □ chin
□ massiter size □ jaw line □ jowels □ neck fat □ neck lines □ unwanted hair □ migraine
□ excessive sweating □ bells palsy □ blepherspasm □ Temporomandibular joint pain ☐ neck pain
□ knee arthritis □ sensitive skin □ skin colour □ pigment sun spots □ Melasma □ red vessels □ flushing
□ rosacea □ acne □ texture □ tone □ acne scars □ scars □ neck skin
Other_____

TREATMENTS I AM INTERESTED IN (please check all that apply)

□ cosmetic Botox (forehead, eyes, lower face, chin, neck)

□ therapeutic Botox (hyperhidrosis, migraine, knee pain, TMJ, neck pain)

□ dermal filler □ Radiesse □ Sculptra □ hydra facial □ microdermabrasion

□ skin health □ ZO □ Skin Medica □ Glo □ AQ serum □sun screen

□ IPL (Intense Pulsed Light) □ Venus Viva □ Venus Legacy

□ 1540 non-ablative laser □ CO_2 ablative laser

□ AQ serum for vaginal dryness □ AQ serum for Hair growth

□ Cool Sculpting (neck, upper arms, brow line, abdomen, flanks, thighs) □ Belkyra

□ Other _____

CONSENT

I, authorize Dr. Martin Ray and staff of View Laser Skin Rejuvenation to take before and after photographs. Photos are an expected standard of care. Photos will remain a confidential component of my medical record.

Name: please print _____

Signature:_____ Date: _____