Dr. R. van Aardt
Cosmetic Medicine

CONFIDENTIAL MEDICAL/HEALTH INTAKE

Name: _____ Date of Birth: _____ ___F ___M
Health Card #: _____ Exp: _____ ___Other
Mailing Address: _____ Tel # Cell _____-_____-_____
City: _____ Prov: _____ Postal Code: _____ Home _____-_____-_____
Country: _____ Occupation: _____ Work _____-_____-_____x____
Email: Consent to use: ___Y ___N

How did you hear about us: Social Media:__Name:_____ Website:__ Radio:__ Drive-by:__ Friend:__ Newspaper :__ Other:

Please check ALL that apply:

__ Skin Tightening Procedures
__ Microdermabrasion/Chemical Peels
__ Laser Spider Vein Treatments
__ Laser for Sun Damage
__ Botox (Frown/Crows feet)
__ Facial Veins
__ Tattoo Removal
__ Laser Liver spots/Age spots
__ Laser for Wrinkles & Lines
__ Dermal Filler (Folds/Volume loss)
__ Hyperhydrosis (Excessive Sweating)
__ Acne Treatments
__ Acne Scar Treatments
__ Other:
__ Skin Care
__ Products
__ Hair Removal
__ TMJ/Migraine

Allergies:

Patients with chronic infections, especially chronic sinusitis or toothaches may be more likely to experience inflammatory reactions to Injectable fillers. **Do you have any Sinus / Teeth problems**? Y__ N__

Are you currently using any Medications: (Occasionally or regularly)
__ ASA __ Ibuprofen __ Hormones
__ Diuretics __ Vit. C __ Vit A Acid __ Vitamins __ Tranquilizers __ Cortisone __ Anticoagulants
__ Sleeping Pills __ Antibiotics __ Herbal Supplements __ Other: (List)_____
Are you currently or have you been on the drug Accutane in the past 6 months?__Y__N If YES, when did you start or stop?

Medical History: Childhood illness: _____
Surgeries (Including Facial, plates, screws or implants, pacemaker): _____
Are you currently under Physician care: Endocrinologist or Dermatologist?__Y__N If YES, why?

__Acne	__Arthritis	__Asthma	__Autoimmune Disease	__Cancer/Melanoma	__Melanoma	__High Blood Pressure
__Psoriasis	__Diabetes	__Vitiligo	__Hormonal Therapy	__Kidney Disease	__Haemophilia	__Low Blood Pressure
__Planters Warts	__HIV / AIDS	__Mycosis	__Cold Sores / Herpes	__Hepatitis B	__Hepatitis C	__Steroid Therapy
__Tuberculosis	__Phlebitis	__Varicose Veins	__Oedema (Heavy Legs)	__Claustrophobia	__Eczema	__Polycystic Ovarian Syndrome
__Epilepsy	__Hirsutism	__Keloid Scar	__Psychiatric Disorders	__Heart Disease	__Depression	__Body Dysmorphic Disorder

Have you or are you getting radio/chemo?__Y__N Have you ever had Gold Therapy? __Y__N Tattoos or Permanent makeup? __Y__N
Do you go to Tanning Salons? __Y__N Do you get Light triggered headaches? __Y__N Do you bruise easily? __Y__N
Do you use Sunscreen regularly? __Y__N Do you have any Implants Dental or Body? __Y__N Do you bleed easily? __Y__N
Ever had any Cosmetic Treatments like Botox, Fillers, Laser, Skin Tightening?__Y__N If YES, when and where?

Tobacco, Vaping, Cannabis Product use: __ Never __ Rarely __ Once a week __ Daily
Alcohol use: __ Never __ Rarely __ Once a week __ Daily

Do you drink any of the following on a regular basis:
__ Water __ Tea __ Coffee __ Soft Drinks __ Sport Drinks __ Wine
__ Juice __ Herbal Tea __ Caffeinated Drinks __ Energy Drinks __ Hard Liquor __ Beer

Pregnant or trying to get pregnant? __Y__N Are you Menopausal? __Y__N Have you had a Hysterectomy? __Y__N
Are your periods regular? __Y__N Are you using Oral Contraceptive? __Y__N How many Children have you had? _____

I hereby authorize the Service Providers and medical staff of this Medi-Spa, to perform medical and/or aesthetic examinations, diagnostic and treatment procedures on myself or the patient named (if under 18) as ordered by the attending physician. I assume full responsibility of charges not covered by insured agencies. By signing below, I hereby certify that all the above information are true, accurate and complete to the best of my knowledge.

_____ _____ _____
PRINT NAME **SIGNATURE OF PATIENT OR RESPONSIBLE PERSON** **DATE**

RELATIONSHIP TO PATIENT: