VANCOUVER LASERSKINCARE CLINIC

COSMETIC INTEREST QUESTIONNAIRE

Patient Name: | Date:

General appearance or products of interest to you (please check all that apply).

❑ Skin care consult	❑ Facial veins	❑ Neck elasticity
❑ Skin care products	❑ Facial redness	❑ Lower face elasticity
❑ BOTOX® Cosmetic	❑ Leg veins	❑ Abdominal elasticity
❑ Facial fine lines	❑ Brown spots/age spots	❑ Make-up consultation
❑ Facial wrinkles	❑ Longer eyelashes	❑ Hair reduction
❑ Thin lips	❑ Drooping eyelids/ Dark circles	❑ Pore size and texture
❑ Blotchy skin	❑ Acne/Acne Scaring	❑ Ultherapy

Please answer the following questions on a scale of 1 to 5 by circling the appropriate number.

When looking at my face in the mirror, I believe I look younger, the same as, or older than my true age.

Younger Than		*True Age*		*Older Than*
1	2	3	4	5

People perceive me as looking angry or tired or sad even when I am not.

Not Concerned		*Somewhat Concerned*		*Very Concerned*
1	2	3	4	5

I have noticed the discoloration of my skin. The tone and texture and unevenness bother me.

Not Concerned		*Somewhat Concerned*		*Very Concerned*
1	2	3	4	5

When I look into the mirror, the skin on my jawline and neck appear to be sagging.

Not Concerned		*Somewhat Concerned*		*Very Concerned*
1	2	3	4	5

Drooping eyelids are a problem for me.

Not Concerned		*Somewhat Concerned*		*Very Concerned*
1	2	3	4	5

I'm concerned about make-up clogging my pores, not giving me enough coverage, or not easy to use.

Not Concerned		*Somewhat Concerned*		*Very Concerned*
1	2	3	4	5

Patient Signature: _____

Update Phone:

Update Email:

Update Address:

PATIENT INFORMATION Date:_____

Name:_____

Address:_____

City:_____State:_____Zip:_____

Home Phone:_____ Work Phone:_____

Cell Phone:_____Email:_____

Employer:_____ Occupation:_____

Birthdate:____/____/____ Age:_____ Sex: Female_____ Male_____

Emergency Contact Name:_____

Phone:_____ Relationship:_____

How did you hear about us? _____ Did a friend/relative refer you? If so:
Name:_____

May we thank them for the referral? Yes____ No____

HISTORY:

Are you allergic/reactive to any medications, products, or skin care ingredients?

If so, please list:_____

Do you currently have, or have a history of any medical conditions (diabetes, thyroid disorder, hormone imbalance, high blood pressure, hepatitis, skin cancer, heart problems, vitiligo, coagulopathies, wound infections, keloids, or hypertrophic scarring?

If so, please list:_____

Are you pregnant or nursing? Yes_____ No_____

Do you have a history of Herpes? Yes____ No_____ Last Outbreak If so:_____

Have you had Gold Therapy, for Rheumatoid Arthritis? Yes____ No_____
If so when? _____

Have you had a recent surgery? Yes____ No____
If so when? _____

List any medications, vitamins, or other nutritional supplements/herbs that you take on a regular or occasional basis (including aspirin):_____

Have you recently used any special creams or medications to treat a skin condition?
If so, please list: _____

Do you experience big mood swings in your mood or suffer from depression or anxiety? Yes____ No____

Do you have permanent makeup or tattoos? Yes____ No____ If so what areas?
_____

Do you smoke? Y/N
Exercise regularly? Y/N
Wear Contacts? Y/N
Do you take diet pills? Y/N
Do you drink caffeinated beverages? Y/N – If yes how much daily?_____
Do you regularly use a sunscreen on your skin? Y/N – If yes, usual SPF_____
How many alcoholic beverages do you consume ?__daily__weekly__monthly__ rarely
Have a pacemaker or defibrillator? Y/N
Have implants or metal implants? Y/N
Do you take diuretics or laxatives? Y/N
How much water do you drink daily?_____
Do you have ___oily___dry___or___acne-prone skin?

Skin type, or when exposed to the sun WITHOUT PROTECTION for approx. one hour:
___I Always burns, never tans
___II Always burns, sometimes tans
___III Sometimes burns, sometimes tans
___IV Always tans
___V Hispanic__Mediterranean__Middle Eastern
___VI Black
What is your national origin? _____

Do you have any Native American in your family history? Y/N

Do you have any Italian in your family history? Y/N

Do you blush easily when nervous? Y/N Do you often experience facial redness/flushing? Y/N

Do you use self-tanning lotions? Y/N Most recent use:_____

Do you use a tanning bed? Y/N Most recent use:_____

When was your last significant exposure to the sun with little or no sunscreen?
_____

Are you planning a holiday in the sun? Y/N If so when?_____

What methods do you or have you used for hair removal? __shaving__electrolysis
__tweezing__waxing__bleaching__creams(Nair)__

Prior treatment with Intense Pulse Light? Y/N If so when? _____

Have you had a chemical peel? Y/N What type?_____Most recent?_____

Have you had a microdermabrasion? Y/N Most recent?_____

Previous Botox? Y/N Most recent ? _____Area treated? _____

Previous Collagen? Y/N Most recent? _____Area treated? _____

Do you experience skin breakouts? Y/N Can you relate it to any cause?_____

Do you ever experience these conditions on your skin? __oily _tightness__dryness
What type of skin care products are you currently using? _____
bar soap__cleanser__toner__masque__moisturizer__scrub/peel__other_____

Do you have any other issues or questions that you would like us to address today? Please specify:
_____

What are your expectations from your treatment here?_____
_____

_____
Can we take your photos for your files? ____Yes ___No

Thank you…..This information is completely confidential, and will be used only to help us give you the best care possible.