the IV health centre

Today's Date (D/M/Y) _____

Medical Aesthetics Intake Form

Name _____ Date of Birth (D/M/Y)_____

Address _____ City_____

Postal Code _____ Phone _____

Email_____ Occupation_____

Primary Health Care Provider _____

Emergency Contact _____ Phone _____

Note: By providing your email address you are giving us consent to send you email confirmations for your appointments as well as The IV Wellness Boutique Inc. specials and newsletter.

Did someone refer you to the IV? _____

Other Health Care Providers

Name _____ Name _____

Profession _____ Profession _____

Phone _____ Phone _____

Health information

Have you had any aesthetic procedures? (Laser, IPL, peels, microderms) ○ Yes ○ No

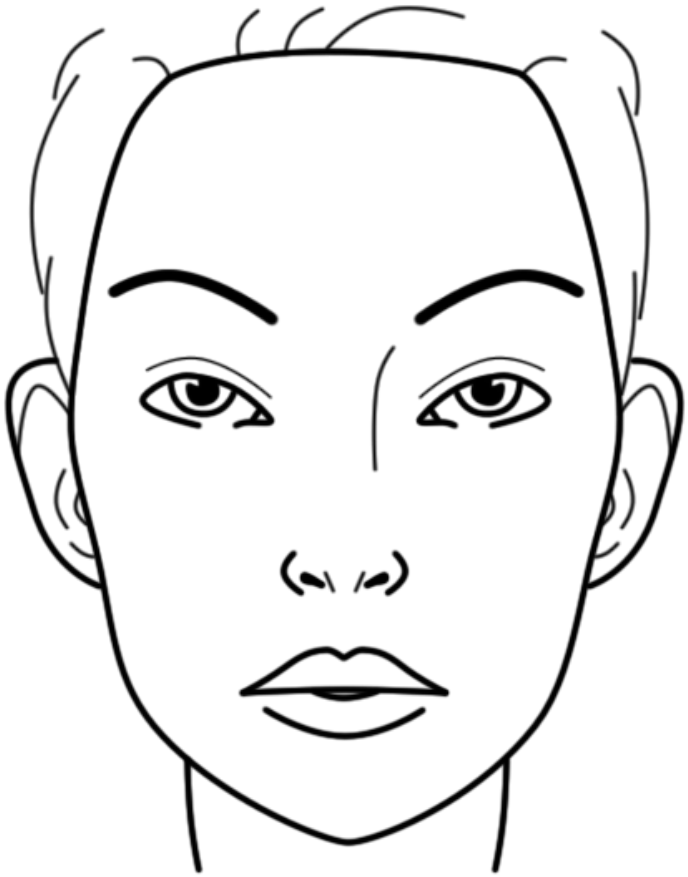
- If yes, when was the last treatment? _____

Have you had botox or fillers before? ○ Yes ○ No

- If yes, what treatment did you have? _____
- When was the last treatment? _____
- Any complications or concerns from the injections? _____

_____

Please indicate on the diagram below areas of concern and description:



Skin Indications for Treatment (check appropriate boxes)

- ○ Acne and/or acne scarring
- ○ Blocked pore/follicles
- ○ Problem prone skin
- ○ Dry, dehydrated skin
- ○ Fine lines
- ○ Sensitive skin
- ○ Facial erythema (redness)
- ○ Photo damage
- ○ Dull skin
- ○ Improve skin texture

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Allergies and sensitivities

List all allergies to medications, environment and food:

1. _____ Reaction _____

2. _____ Reaction _____

3. _____ Reaction _____

IMPORTANT: Have you ever experienced an allergic reaction to any treatment, anaesthetic or substance ie. aspirin, dental freezing, peanuts etc. YES or NO?

If yes please explain: _____

Supplements and medications

List all supplements you are currently taking:

Supplement	Daily Dose	How Long	Reason

List all medications you are currently taking:

Medication	Daily Dose	How Long	Reason

Are you currently or have you in the past taken prescription drugs for a skin condition such as Accutane, Tazorac, Retin-A, Antibiotics, Corticosteroids, etc.?

_____

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Medical history

List any health condition(s) that you have been diagnosed with:

1. _____ Date _____

2. _____ Date _____

Do you have any immune disorders? Rheumatoid arthritis, scleroderma, or lupus? ○ Yes ○ No

- If yes, what medication(s) do you take? _____

Do you have any thyroid problems? ○ Yes ○ No

- If yes, what medication(s) do you take? _____

Do you have a history of Kelodial scarring? ○ Yes ○ No

Lifestyle

Have you recently had any change in your diet, beauty regimen, etc?

○ Yes ○ No If yes, please explain: _____

Have you used active skincare products in the past, or are you presently using active skincare products such as Alpha Hydroxy Acids or Retinol?

_____

Please identify which skincare products you are currently using:

_____

_____

_____

_____

_____