DRS. YOUNG & WOUTERS
CALGARY VEIN & LASER

ESTHETIC HISTORY QUESTIONNAIRE

NAME: _____ **DATE:** _____ **DOB:** _____

ADDRESS: _____ **PHONE:** _____ **AHC#:** _____

E-MAIL ADDRESS: _____ **WEBSITE:** _____

OCCUPATION: _____ **HT:** _____ **WT:** _____

1. How did you hear about us: ☐ newspaper ☐ yellow pages ☐ friend(name)_____

   ☐ Conferences/exhibitions ☐ referring physician (name)_____ ☐ other_____

2. How long did you have to wait between making our appointment and your actual appointment time? _____

3. Reason for consultation:

   ☐ Wrinkles ☐ Skin care ☐ Facial veins ☐ Skin pigment removal

   ☐ Mole removal ☐ Skin Tags ☐ Laser hair removal ☐ Peels - Glycolic, Diamond, Aspirin, Blue peel

   ☐ Rosacea ☐ Facial resurfacing ☐ Tissue Fillers – Restylane, Perlane, Artecoll, Collagen

   ☐ Botox ☐ Acne ☐ Skin care program – Dr. Perricone, Obagi, Medique, Cosmedix

   ☐ Other _____

4. Any previous cosmetic treatment? ☐ Yes ☐ No If yes, explain _____

5. Have you used or are you currently using:

Retin A	☐ Yes	☐ No
Accutane	☐ Yes	☐ No
Alpha hydoxy acid	☐ Yes	☐ No

6. List skin care products you are presently using: _____

7. Do you tan easily? ☐ Yes ☐ No Do you burn with sun exposure? ☐ Yes ☐ No

8. Check below if you have had any of the following:

   ☐ Scleroderma ☐ Poor healing ☐ Arthritis ☐ Lupus ☐ Keloid healing

   ☐ Herpes (cold sores) ☐ Tuberculosis ☐ High Blood Pressure ☐ Valvular Heart Disease

   ☐ Heart Disease ☐ Endocarditis ☐ Cancer ☐ Hepatitis, type _____

   ☐ Thyroid Problems ☐ Vitiligo ☐ Arterial problems ☐ HIV/AIDS

   ☐ Asthma ☐ Hay Fever ☐ Eczema ☐ Hives

9. List other medical problems from which you are suffering that has not been mentioned in question eight:

   _____

10. List Surgeries & date

    _____

    _____

    _____

    Family History of above (List below)

    _____

    _____

    _____

SEE OVER

11. List all medication, vitamins & herbs presently taking:

_____ _____

_____ _____

_____ _____

_____ _____

12. Do you smoke? ☐ Yes ☐ No If yes, how many cigarettes per day? _____

13. Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, what year? _____

14. Do you exercise on a regular basis? ☐ Yes ☐ No

15. Have you had an AID's test? ☐ Yes ☐ No

16. Do you have allergies to: ☐ Aspirin ☐ Iodine ☐ Tapes/Bandages ☐ Xylocaine(Dental Freezing) ☐ Seafood

List allergies to other medication or food etc. _____ _____ _____

_____ _____ _____

Have you any allergies to skin care products? ☐ Yes ☐ No If yes, explain _____

FOR FEMALES ONLY:

Are you currently pregnant? ☐ Yes ☐ No

Are you planning on becoming pregnant? ☐ Yes ☐ No

Are you currently breast-feeding? ☐ Yes ☐ No

SEE OVER