



Kamloops Skin Solutions
250.372.9995
MAUREEN T.
LEIA-STEPHEN
M.D. F.R.C.S(C)

Cosmetic Consultation

| | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|--------------------------------------------|
| Name: | PHN: | Birthdate: | | |
| Address: | City: | Postal Code: | | |
| Home Phone: | Work: | Cell: | | |
| Permission to contact you for appointment reminders by text? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Email Address: | Permission to contact you by email? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | <input type="checkbox"/> Newsletter <input type="checkbox"/> Events | | | |
| Emergency Contact & Relationship: | Emergency Contact Phone: | | | |
| Family Physician: | Occupation: | | | |
| Current Medications | | | | |
| Previous Surgeries | | | | |
| Drug Allergies | | | | |
| Latex Allergy? <input type="checkbox"/> Yes <input type="checkbox"/> No | Height: | Weight: | | |
| How did you hear about us? | <input type="checkbox"/> Word of Mouth | <input type="checkbox"/> Friend/Client Here | <input type="checkbox"/> Instagram | |
| | <input type="checkbox"/> Google/Website | <input type="checkbox"/> Facebook | <input type="checkbox"/> Other _____ | |
| Lifestyle | | | | |
| Cigarettes? <input type="checkbox"/> Yes <input type="checkbox"/> No Cigarettes per day? | Years smoked? | | | |
| Alcohol/Drinks per week? | Exercise & Frequency per week? | | | |
| Personal History | | | | |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Seizures | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Bleeding Problems |
| <input type="checkbox"/> Previous Stroke/ TIA | <input type="checkbox"/> Cancer | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Migraines | |
| <input type="checkbox"/> Other (please list) | | | | |
| Have you ever been documented to be a carrier of an antibiotic resistant organism (ARO)? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| Do you actively tan (inside or outside)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when was your last session? | | | | |
| Do you use: Retinol <input type="checkbox"/> Yes <input type="checkbox"/> No How often? | | Glycolic Acid <input type="checkbox"/> Yes <input type="checkbox"/> No Salicylic Acid <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Do you have a history of Rosacea? | <input type="checkbox"/> Yes <input type="checkbox"/> No | How do you manage? | | |
| Do you have a history of Melasma? | <input type="checkbox"/> Yes <input type="checkbox"/> No | How do you manage? | | |
| Have you used Accutane? | <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, was this within the last 6-12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Have you been treated for skin cancer? | <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, when and where? | | |
| Have you been treated for Actinic Keratosis? | <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, when and where? | | |
| Have you EVER had a cold sore? | <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, when was your last outbreak? | | |
| Do you have any immune disorders? Rheumatoid Arthritis, scleroderma, lupus? | | | | |



List previous aesthetic procedures

| | | Last Treatment | |
|---------------------------------------|----------------------------------------------------------|----------------|---------|
| | | Year | Results |
| Botox | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Dermal Filler | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| IPL | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Laser Resurfacing | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Microneedling | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Secret – Microneedling with RF | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Thermage - Radiofrequency | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Ulthera | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Vascular Laser | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Body Contouring | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

Reason(s) for Requested Consultation/Concerns:

- Aging (Fine lines/Wrinkles)
 Rosacea/Redness
 Discoloration (Sun spots/Melasma)
 Skin Texture and Tone
 Acne
 Other _____

Where can we help?

| | | |
|-----------------------|----------------------------------------------------------|-----------|
| Forehead: | <input type="checkbox"/> Yes <input type="checkbox"/> No | Concerns: |
| Eyes: | <input type="checkbox"/> Yes <input type="checkbox"/> No | Concerns: |
| Lips: | <input type="checkbox"/> Yes <input type="checkbox"/> No | Concerns: |
| Lower Face: | <input type="checkbox"/> Yes <input type="checkbox"/> No | Concerns: |
| Neck: | <input type="checkbox"/> Yes <input type="checkbox"/> No | Concerns: |
| Hands: | <input type="checkbox"/> Yes <input type="checkbox"/> No | Concerns: |
| Skin Laxity: | <input type="checkbox"/> Yes <input type="checkbox"/> No | Concerns: |
| Feature Accentuation: | <input type="checkbox"/> Yes <input type="checkbox"/> No | Concerns: |
| Complexion: | <input type="checkbox"/> Yes <input type="checkbox"/> No | Concerns: |
| Other: | <input type="checkbox"/> Yes <input type="checkbox"/> No | Concerns: |

I hereby certify that the above information is true and correct as to the best of my knowledge.

Signature

Date