PATIENT QUESTIONNAIRE

NAME: _____ _____
First Name *Last Name*

EMAIL: _____
Granting permission to provide electronic communication, educational information & promotions

DATE OF BIRTH: (D) _____ (M) _____ (Y) _____ ☐ MALE ☐ FEMALE

PHONE: (Best Daytime Number) _____ OCCUPATION: _____

HOME PHONE # _____ WORK PHONE # _____

MOBILE PHONE #_____

ADDRESS: _____ APT/UNIT #_____

CITY _____ POSTAL CODE _____

MEDICATIONS: _____

☐ ASA HERBAL PRODUCTS _____ Do you have ODSB or Trillium Drug Plan? (circle)

DRUG ALLERGIES: _____ PREGNANT: ☐ YES ☐ NO

REFERRED BY: _____

MAIN REASON FOR CONSULT? _____

MEDICAL HISTORY: ☐ Diabetes ☐ Arthritis ☐ Bleeding Disorders ☐ Hepatitis ☐ Myasthenia Gravis

☐ Acne ☐ Eczema ☐ Psoriasis ☐ Rosacea ☐ Vitiligo ☐ Cold Sores ☐ Keloids ☐ Cancer ☐ HIV

Other _____

How did you hear about us? ☐ Physician ☐ Website ☐ Friend _____

Are you interested in Cosmetic Dermatology Services? ☐ *YES* ☐ *NO*

☐ Botox ☐ Injectable Fillers ☐ Our Skin Care Products ☐ Photorejuvenation (IPL) ☐ Treatment of Facial Veins

☐ Sclerotherapy ☐ Chemical Peels ☐ Microdermabrasion ☐ Improving Skin Tone/Texture/Colour ☐ Latisse

☐ Improving Sun Damaged Skin ☐ Eliminating Excessive Sweating ☐ Medical Grade Facials

***<u>Please bring your completed questionnaire and and your OHIP (healthcard) to your appointment</u> ***