Ancaster Laser Medispa – CLIENT REGISTRATION

Surname: ______________________________ **First Name:** ______________________

Birthdate: _____________________________ **Sex: Male**_____ **Female**______

Street Address: __________________________ **APT #** _________________

City: ________________________________ **Postal Code:** _________________

Home Phone: __________________ **Business Phone #** _______________________

Cell: _______________________ **email:** _________________________

Please indicate which telephone number we can use to contact you during the day:

Business Home Other ________________________________

MEDICAL HISTORY: CIRCLE IF YOU HAVE/HAD ANY OF THE FOLLOWING:
Any Skin Disorder (Psoriasis, Eczema, Acne, Rosacea, Melasma, Other), Cold Sores, Herpes, Shingles, History of Seizures, Immunosuppressive Disorders (cancer,diabetes,), Allergies to Medications, food or other. Hepatitis

Are you currently on any Medications or are you taking Supplements? ________________________
Are you Pregnant or planning pregnancy in the near future? _________________________

HOW DID YOU HEAR ABOUT US?

Friend (Print Name) ____

Advertisement (Print Source) __________________________________

Other (please explain) _______________________________________

Please CIRCLE any topics you are interested in learning more about:

Skin Care Products	Chemical Peels	Acne Treatments
Reducing Wrinkles	Reducing Fine Lines	Microdermabrasion
Improving Skin Tone	Improving Skin Texture	Botox®
Rosacea Treatments	Minimizing Pore Size	Lip Enhancements
Correct Sun Damage	Body Contouring	Skin Tightening
Laser Hair Removal	Photo-Facial Rejuvenation	Reducing Fat Pockets
Cellulite Treatments	Eliminating Excessive Sweating	

Would you be interested in getting our emails on specials of the months? ___Yes ____No

MEDICAL HISTORY

Last Name: ______________________________

First Name: ______________________________

Address: ______________________________

City: ______________ Prov: __________ Postal Code: ______________

Telephone: Home: # ______________ Work #: ______________

Date of Birth M ______ D ______ Y ______ Sex: M / F

Family Doctor: ______________________________

Please answer **ALL** of the following questions:		Yes	No
1.	Do you have ANY current or chronic medical illnesses? Please list:	☐	☐
2.	Do you take ANY medications on a regular or daily basis? Please list:	☐	☐
3.	Do you have ANY allergies to medicine or skin sensitivities? Please list:	☐	☐
4.	(for women) Are you pregnant?	☐	☐
5.	(for women) Are menstrual periods regular?	☐	☐
6.	Do you have a history of herpes simplex in the area to be treated?	☐	☐
7.	Do you have a history of keloid scarring?	☐	☐
8.	Have you taken Accutane or anticoagulants in the last 6 months?	☐	☐

9. To determine skin type, check one of the following:

Type		Colour	Reaction to First Sun Exposure Yearly
______	I	white	always burn / never tans
______	II	white	usually burns / tans with difficulty
______	III	white/asian	sometimes mild burn / average tan
______	IV	moderate brown	rarely burn / tans with ease
______	V	dark brown	very rarely burns / tans very easily
______	VI	black	never burns

Signature: ______________________________ Date: ______________