Intake Profile

Date_____

First Name_____ Last Name _____

DOB: m/d/y ____ / ____ / _____ **Alberta Health #** _____

Home Address: _____City_____ Postal Code: _____

Cell phone: _____ Alternate Telephone: _____

E-mail: _____

Pharmacy Name / Location: _____

Employer: _____Occupation:_____

Marital Status: Single Married Divorced Separated Widowed

Emergency Contact: _____ Telephone: _____

What is the primary reason for your visit today?

_____

Do you have / had problems with any of the following:

Headaches	Yes	Skin Infections	Yes
Hives	Yes	Skin Bruising	Yes
Irregular Menses	Yes	Snoring	Yes
Keloid Scarring	Yes	Urine Leakage	Yes
Photo Sensitivity	Yes	Varicose Veins	Yes

Other medical problems _____

Medications:

Any mood altering or anti-depressant medication: _____

List ALL other prescription & over the counter medications, any vitamins or supplements. If none, please write NONE, if you have a prepared list, submit to the reception please.

_____

_____

Allergies

Medication or Foods	Yes	Environmental allergies	Yes
Latex/ Adhesives	Yes	Hyper sensitive to skin products	Yes

Skin Procedures / Major Surgeries and Dates

_____

_____

Please circle procedures you are interested in:

Advanced Skin Analysis	Latisse Eyelash Treatment	Skin Tag / Spot Removal
Acne Control	Medical Facials	Sleep Apnea / Snoring
Botox / Filler	Mineral Makeup	Teeth Whitening
Chemical Peels	MicroNeedling	Vaginal Rejuvenation
Hair Removal	Sclerotherapy	Vaginal Incontinence
Hair Loss Therapy	Skin Resurfacing	Vampire / PRP Facial

How did you hear about DermaNuva?

Website Google FaceBook Instagram Physician Friend or Family

Who can we thank?_____

We do communicate via email regarding your treatments, important updates and results.

For office use only;

S:			
O:			
A:			
P:			
Q:			

_____

Thank you for filling out the above, it will be secured and treated under the Standards of Practice of Confidentiality