Heights LASER CENTRE

Beauty Simply Elevated

Name (First, Last): _____

Address: _____ City: _____ Prov:_____PC: _____

□ Home: ( )_____ □ Cell: ( )_____ □ Work: ( )_____

Gender: □ Female □ Male Date of Birth: (MM/DD/YEAR): _____/_____/_____

BC Carecard #: _____ Email Address: _____

Newsletters and Appointment Confirmations (via text and/or email):

□ Yes, I would like to receive Newsletters, VIP promotions and Appointment Confirmations. I understand I can withdraw consent at any time by contacting us at (604) 298-4481

□ No, I do not want to receive Newsletters, VIP promotions and Appointment Confirmations

How did you hear about us? (Please check all the apply)

□ Google	□ Facebook
□ Bing	□ Instagram
□ Yahoo	□ Advertisements/periodicals
□ Yelp	□ Seminar / Lunch & Learn
□ Other Search Engine	□ Walk by / Drive by
□ Website	□ Family/Friend (name): _____

Sun History & Lifestyle

How often do you work outdoors?	□ Frequently	□ Occasionally	□ Never
How often do you use sunscreen?	□ Frequently	□ Occasionally	□ Never
How often do you use tanning beds?	□ Frequently	□ Occasionally	□ Never

Do you have any of the following Medical Conditions? (Please check all that apply)

□ Cold Sores	□ Diabetes	□ Epilepsy	□ Hepatitis A,B,C	□ Herpes	□ Genital Warts
□ Arthritis	□ HIV/AIDS	□ Lupus	□ Keloid Scars	□ Migraines	□ Psoriasis
□ Thyroid Imbalance		□ Headaches triggered by lights		□ Blood Clotting Abnormalities	
□ High Blood Pressure		□ Any Active Infection		□ Hormone Imbalance	

□ Cancer, if yes, what type and when? _____

Do you have any other health problems or medical conditions? (Please list) □ None

_____

_____

Please list Past Surgical History, procedure and what year? ☐ None

_____

_____

_____

Have you ever had sclerotherapy, EVLT or phlebectomy? ☐ Yes ☐ No

Please list all Medications you are currently taking (including vitamins and minerals): (Please list) ☐ None

_____

_____

_____

_____

Are you taking HRT or Steroids? ☐ Yes ☐ No

Have you ever taken Accutane? ☐ Yes ☐ No

If yes, when did you finish your treatment? _____

Please list all Allergies (medications, products and/or general allergies): ☐ None

_____

_____

_____

_____

For our Female Clients:

Are you pregnant? ☐ Yes ☐ No

Are you trying to become pregnant? ☐ Yes ☐ No

Are you breastfeeding? ☐ Yes ☐ No

I certify that the preceding medical information is correct. I am aware that it is my responsibility to inform the doctor or other health care professional of my current medical or health conditions. A current medical history is essential to execute appropriate treatment procedures.

_____ _____

Signature: Date:

On occasion there may be Physicians or Technicians-in-training on site to observe clinic consultations and/or procedures. You may refuse to have outside observers at any time. Do you consent to these physicians and/or technicians observing your treatment at our clinic?

_____ _____

Signature: Date: