

Date \_\_\_\_\_

## Cosmetic Client Assessment Form

**Name** \_\_\_\_\_

**Date of Birth** (DD/MM/YYYY) \_\_\_\_/\_\_\_\_/\_\_\_\_ **Age** \_\_\_\_\_

**Health Card Number** \_\_\_\_\_

**Address:**

Street \_\_\_\_\_  
City and Province \_\_\_\_\_  
Postal Code \_\_\_\_\_

**Contact Numbers**

Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

**Next of Kin Name** \_\_\_\_\_ Relationship to you \_\_\_\_\_  
*Contact Numbers for Next of Kin if different from above* \_\_\_\_\_

**Family Doctor**

\_\_\_\_\_

**Occupation** \_\_\_\_\_ Current / Retired/ Unemployed / Disabled

**Hobbies/Leisure Activities**

\_\_\_\_\_  
\_\_\_\_\_

**What Procedure(s) are you interested in?**

\_\_\_\_\_  
\_\_\_\_\_

**What do you hope Dr. Nodwell can do for you?**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**How did you hear about Dr. Nodwell?**

- Referred by my doctor
- Recommended by a friend
- Internet Search
- Yellow Pages/Print Advertisement ( \_\_\_\_\_ )

**Past Medical History**

In order for Dr. Nodwell to understand your medical history, it is important that you complete the next two pages to the best of your abilities.

CIRCLE those that apply, including "NONE" and Write Out conditions you have but do not see listed.

**Brain, Spinal Cord and Nerves -**

Epilepsy, Stroke, Mini-Stroke, MS, Neuropathy, Other \_\_\_\_\_NONE

**Psychiatric -**

Depression, Anxiety, Bipolar, Schizophrenia, Other \_\_\_\_\_NONE

**Heart and Circulation -**

Angina, Heart Attack, Poor Circulation, Vein problems, Blood clots, High Cholesterol, High Blood Pressure, Heart Valve Problems, Stents, Other \_\_\_\_\_NONE

**Lungs-**

Asthma, Bronchitis, Emphysema, Other \_\_\_\_\_NONE

**Stomach and Bowels -**

Heart Burn, Ulcers, Inflammatory Bowel Disease, Hepatitis, Cirrhosis, Other \_\_\_\_\_NONE

**Bladder and Kidneys -**

Kidney failure, Incontinence, Enlarged Prostate, Other \_\_\_\_\_NONE

**Endocrine and Hormones -**

Diabetes, Thyroid Disorder, Other \_\_\_\_\_NONE

**Muscles, Bones and Joints -**

Arthritis, Bursitis, Osteoporosis, Fibromyalgia, Other \_\_\_\_\_NONE

**Skin -**

Eczema, Psoriasis, Heavy Scarring, Other \_\_\_\_\_NONE

**Bone Marrow and Blood -**

Bleeding/Clotting disorders, Anemia, Platelet disorder, Lymphoma, Other \_\_\_\_\_NONE

**Immune System**

Autoimmune disease, HIV, Chemotherapy, Immunosuppressive drugs, Other \_\_\_\_\_NONE

**Other -**

Cancers, Infections, Other \_\_\_\_\_NONE

**YOUR INITIALS \_\_\_\_\_**

**Past Surgical History**

(Previous procedures, including those in childhood, dental surgery and cosmetic procedures).

Procedure
_____
_____
_____
_____
_____
_____

Adverse Reactions (Bleeding, Anaesthetic problems)
_____
_____
_____
_____
_____
_____

**Medications -**

Include **ALL** prescription and non-prescription medication, vitamins and supplements.

_____
_____
_____
_____
_____
_____

**Allergies (to Medications, Latex, Surgical Tapes etc)**

Substance
_____
_____
_____

Reaction
_____
_____
_____

**Social History**

Consumption of -

Alcohol (Drinks per day) \_\_\_\_\_

Cigarettes (Packs per day) \_\_\_\_\_ Number of Years \_\_\_\_\_

Other Drugs \_\_\_\_\_

**Family History**

(Conditions arising in blood relatives, particular emphasis on cancers, heart disease, diabetes, bleeding disorders and reactions to anaesthetics).

_____
_____

**YOUR SIGNATURE** \_\_\_\_\_ **Date** \_\_\_\_\_