preventous
COSMETIC MEDICINE

Patient Health History

First Name: _____ LastName: _____

Date of Birth: _____ Health Care Number: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Do you take any of the following:

- ☐ Blood Thinner
- ☐ Anti-Inflammatories
- ☐ Vitamin E
- ☐ Ginko Biloba
- ☐ Aspirin
- ☐ Other:

Do you suffer from urinary incontinence (stress or urgency) or postpartum leakage? ☐ Yes ☐ No

Please list any Current Medication(s):

_____
_____
_____
_____

Please describe any allergies and the reaction to allergen:

_____
_____
_____

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Please provide any medical history:

_____
_____
_____
_____

Please provide your surgical history:

_____
_____
_____

Sun Exposure accrued (Lifetime): ☐ Extensive ☐ Moderate ☐ Light ☐ Minimal

☐ Are you prone to Keloid scar formation (raised scars that grow beyond the boundaries of the original wound)?

☐ Are you pregnant

☐ Are you breast feeding?

☐ Do you have a history of cold sores/Herpes I or II?

☐ Do you smoke?

☐ Are you taking or have taken Accutane for acne?

☐ Have you been diagnosed or treated for skin cancer?

☐ Do you wear sunscreen daily?

If you have been diagnosed with skin cancer what kind and what treatment did you have?

_____
_____
_____

When is the last time you had a physical? ☐ Less than a year ☐ Greater than a year ☐ N/A

When is the last time you had bloodwork done? ☐ Less than a year ☐ Greater than a year ☐ N/A

When is the last time you saw an optometrist? ☐Less than a year ☐Greater than a year ☐N/A

What are the concerns that prompted you to contact our clinic?

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_____

_____

_____

How would you rate the quality of your skin? ☐Poor ☐Fair ☐Good ☐Very Good ☐Excellent

If you could enhance an aspect of your skin, what would you enhance?

- ☐ Hydration
- ☐ Elasticity
- ☐ Tone
- ☐ Texture
- ☐ Other:

I would like to be advised on:

- ☐ How I can change something that has been bothering me for years
- ☐ How I can look more attractive
- ☐ How I can look better for my age:
- ☐ Other:

Have you had a consultation for a cosmetic procedure? Yes No

How Often do you think about wanting a cosmetic procedure?

- ☐ Most days
- ☐ Weekly
- ☐ Monthly

Which three statements best reflects how you would like to look and feel after the treatment?

- ☐ I want to look less tired
- ☐ I want to look less angry
- ☐ I want to look less sad
- ☐ I want a less saggy appearance
- ☐ I want to look more youthful
- ☐ I want to look more attractive

☐ I want my face to look slimmer

☐ I want softer features

How did you hear about us?

☐ Social Media

☐ Family/Friend

☐ Google/Search Engine

☐ I'm a member of Preventous Collaborative Health

☐ Family physician outside of Preventous

☐ MD Skin Shop

☐ Outdoor Signage

☐ Other(please specify):_____

☐ **I would like to receive the e-newsletter.**

Clinic Policies

Preventous Cosmetic Policies

At Preventous, we strive to provide exceptional service while maintaining clear communication and policies for our valued patients. Please review the following carefully:

1. Appointment Policies

- **Rescheduling or Cancellations:**
  - A minimum of **2 business days' notice** is required to reschedule or cancel any appointment.
- **Deposit Policy for Treatments 30 Minutes or Longer & Packages**:
  - Treatments such as Dermal Fillers, Ultherapy, or CoolSculpting require a **deposit** at the time of booking.
  - The deposit will be applied toward the cost of your treatment.
  - If you fail to cancel or reschedule with 2 business days' notice, your **deposit will be retained**.
- **Individually Purchased Treatments (e.g., Botox, HydraFacials):**
  - If you miss an appointment or fail to provide adequate notice, a **$50 + GST service charge** will be applied to your next visit.
- **Late Arrivals:**
  - Please arrive on time for your scheduled appointment.
  - Arriving late may result in the loss of your appointment and **forfeiture of your deposit**.
- **Missed Appointments:**
  - Missed appointments are subject to the same cancellation policy. Alternatively, a **$50 + GST service charge** will apply to your next visit.

☐ **I acknowledge the Appointment Policies.**

2. Prepaid Packages

- All prepaid packages must be used within **1 year of the purchase date**.

☐ **I acknowledge the Prepaid Packages policy.**

3. Rejuvenation Program Quotes

- Quotes provided in your personalized Rejuvenation Program are valid for **3 months** from the issue date.

☐ **I acknowledge the Rejuvenation Program Quotes policy.**

4. Photographs

- **Mandatory Documentation:**

- Photographs are required as part of your patient journey for documentation, treatment planning, and visual comparison. Photographic documentation is part of your medical chart and necessary to proceed with treatment.

- **Permissions:**
  - Preventous Inc. is granted permission to retain and use clinical photographs for:
    - Your medical chart.
    - In-house marketing. ☐ **Yes** ☐ **No**
    - Consultative purposes. ☐ **Yes** ☐ **No**
  - For advertising purposes, additional consent will be required.
- **Waiver:**
  - By acknowledging this policy, you waive the right to inspect or approve how photographs are used in the specified contexts.

☐ **I acknowledge the Photographs policy.**

5. **Skin Care Products**

- **Final Sale Policy:**
  - All skin care product sales are **final** and non-refundable, except under specific conditions outlined below.
- **Exchange or Refund Policy:**
  - Exchanges or refunds are allowed only in the following cases:
    1. **Defective Products:** If the product is found to be defective.
    2. **Allergic Reactions:** If the product causes an allergic reaction.
       - To determine if an exchange or refund is applicable, you must schedule a consultation with one of our providers. The provider will assess the situation before proceeding.
- **General Exchange Policy:**
  - Exchanges are permitted under the following conditions:
    1. The product is **unopened** and in **pristine condition** (box intact and undamaged).
    2. The return is made within **30 days of purchase** with a valid **receipt**.
  - Products that are **opened**, **damaged**, or within **3 months of expiration** are **not eligible** for exchange or refund unless they meet the above exceptions.

☐ **I acknowledge the Skin Care Products policy.**

Patient Name: _____ Patient Signature: _____
Date: _____