# VANITY

Patient # _____

**Medical Assessment**

**Date: _____**

Name: _____
Address: _____
Phone number: _____
Family Doctor: _____
OHIP #: _____

DOB: _____
Gender: M / F

**Treatment Goals:**

_____

_____

**Past Medical History (if any, describe below)**

| | | | |
|---|---|---|---|
| ☐ Diabetes | ☐ Alcohol | ☐ Cancer | ☐ Anesthetic rxn? |
| ☐ Pregnancy/ OCP | ☐ Smoking | ☐ Cardiac / Heart | ☐ Skin Infections? |
| ☐ Blood Thinner | ☐ Surgeries | ☐ Lung/ Resp | ☐ Infection any? |
| ☐ HIV/HEP | ☐ Cold sores | ☐ Immune d/o | ☐ High BP |
| ☐ MSK Problem | ☐ Bleeding prob? | ☐ Keloid/ Scar | ☐ Drug use? |
| ☐ Blood Clots | ☐ Breast feeding | ☐ Bruising | ☐ Circulation |

Comments/Description: _____

_____

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**Past Surgical History**

| | | |
|---|---|---|
| ☐ Cosmetic surgery | ☐ Anesthetics/ Rxn? | ☐ Dermal Filler / Complication? |
| ☐ Major surgery | ☐ Botox / Complication? | |

Comments/Description: _____

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**Medications (List) ☐ None**

**Allergies: _____ ☐ NKDA**

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| | | |
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| | | |

Comments/Description: _____

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**Other Concerns/ Comments:**

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