DR. LLOYD VAN WYCK MD FRCSC
Cosmetic Plastic Surgeon

CONFIDENTIAL PATIENT INFORMATION

FAMILY NAME: FIRST NAME:

STREET ADDRESS: APT:

CITY / PROVINCE: POSTAL CODE:

HOME PHONE: BUSINESS PHONE: MOBILE PHONE:

EMAIL ADDRESS: HEIGHT: WEIGHT:

Please indicate your preferred method of contact: ☐ HOME ☐ BUSINESS ☐ MOBILE ☐ EMAIL

BIRTHDATE: DD / MM / YYYY AGE: HEALTHCARD: # OF CHILDREN:

EMPLOYER: OCCUPATION: MARITAL STATUS: ☐ M ☐ S ☐ D ☐ W

CONSULTATION CONCERNS

☐ BREAST ☐ EYES
☐ FACE ☐ EARS
☐ ABDOMEN ☐ NOSE
☐ FAT ☐ SKIN CARE

HOW DID YOU HEAR OF OUR CLINIC

☐ DOCTOR REFERRAL ☐ YELLOW PAGES
☐ FRIEND REFERRAL ☐ LOCATE A DOC
☐ ARTICLE/DVERTISEMENT ☐ OTHER CLINIC
☐ WEBSITE ☐ OTHER

HAVE YOU OR WILL YOU BE CONSULTING ANOTHER SURGEON REGARDING THIS CONCERN? ☐ YES ☐ NO

Do you have any bleeding problems? ☐ YES ☐ NO
Heart disease/High blood pressure? ☐ YES ☐ NO
Do you smoke cigarettes? ☐ YES ☐ NO
Do you have diabetes or other metabolic problem? ☐ YES ☐ NO
Have you been under the care of a psychiatrist? ☐ YES ☐ NO
Do you take ASA (Aspirin)? ☐ YES ☐ NO

PLEASE LIST:

PAST SURGERY:

MEDICAL CONDITION(S):

PRESCRIPTION MEDICATION(S):

DRUG ALLERGIES:

NON-SURGICAL COSMETIC SERVICES AND AESTHETIC SERVICES OFFERED *(Please check topics of interest)*

☐ REDUCING WRINKLES AND FOLDS
☐ ENHANCING AND DEFINING LIPS
☐ BOTOX COSMETIC TREATMENTS
☐ INJECTABLE SOFT TISSUE FILLERS
☐ CO2 LASER RESURFACING
☐ FRACTIONATED SURFACING
☐ ACNE SCARS MANAGEMENT
☐ IMPROVING SUN DAMAGE, BROWN AND AGE SPOTS
☐ IMPROVING SKIN TONE AND TEXTURE
☐ IMPROVING ACNE AND POST ACNE SCARS
☐ IMPROVING UNEVEN SKIN PIGMENTATION
☐ IMPROVING ROSACEA AND BROKEN CAPILLARIES
☐ LASER HAIR REMOVAL
☐ SKIN CARE PRODUCT RECOMMENDATION

SIGNATURE: DATE:

☐ *Please email newsletter or promotional information.*

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