



Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ (m/d/y) Sex: Male \_\_\_ Female \_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Province: \_\_\_\_\_

Postal Code: \_\_\_\_\_ Email: \_\_\_\_\_

Phone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

Family Physician \_\_\_\_\_ Drug Allergies \_\_\_\_\_

**I am interested in:** (Please check all that apply):

Botox Cosmetic \_\_\_

Cosmetic 'Dental Smile Makeover' (veneers) \_\_\_

**Medical History:** Circle the appropriate condition for which you have ever been treated:

Acne	Herpes (or cold sores)	Polycystic ovarian syndrome
Arthritis	Melanoma	Port wine stain
Autoimmune disorder	Hormonal imbalance	Psoriasis Steroid or hormonal therapy
Blood disorder	Keloid scars / other scars	Shingles
Cancer (or radiation therapy)	Kidney disease	Skin pigmentation
Diabetes/Diabetic neuropathy	Local anesthetic sensitivity	Vitiligo
Epilepsy		

Do you use sunscreen? Yes \_\_\_

If "Yes" SPF# \_\_\_\_\_

No \_\_\_\_\_

Please list any past illnesses and all minor & major surgeries:

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

Do you smoke? \_\_\_\_\_ How many per day? \_\_\_\_\_



Please list current medications (including aspirin, birth control, herbal medication, etc.) \_\_\_\_\_

Are you currently being treated for any conditions not listed? If yes, please specify.

Have you ever used (or are currently using) Vitamin A or Glycolic acid? If yes, please specify.

Have you ever used (or are currently using) Accutane? If yes, please specify.

Have you ever had a chemical peel? If yes, please specify.

Have you had laser treatments in the past? If yes, please specify.

Have you had "Botox" or "Derma Filler" treatments in the past? If yes, please specify.

When was the last time you: Waxed \_\_\_ Used a depilatory \_\_\_\_\_ Area(s) treated? \_\_\_\_\_

What products are you currently using on your skin? \_\_\_\_\_

Do you have any particular skin sensitivities?

Have you ever been treated by an endocrinologist, dermatologist, plastic surgeon? If yes, please specify.

Do you sunbathe, use self-tanning lotions / sprays or use tanning beds? If so, please specify how often?

Are you currently pregnant, breast feeding or do you plan to become pregnant in the next year?

PATIENT SIGNATURE: \_\_\_\_\_

DATE SIGNED: \_\_\_\_\_

DENTIST SIGNATURE: \_\_\_\_\_

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