Medical History

Name: ______________________________Birthdate: __________ (m/d/y) Sex: Male___ Female___

Address: ______________________________ City: ________________ State/ Province: __________

ZIP/Postal Code:__________________ Email: ____
(We will contact you for your recare by e-mail)

Phone: (Home) __________________ (Work) __________________ (Cell) ____________________

How did you hear about our clinic?

- Doctor's referral (print name) ________________________________
- Friend / current patient (print name) ___________________________
- Attended seminar / Trade show (date / location) _________________

Newspaper __ Website/Internet __ Coupon __ Yellow Pages __ Magazine __ Walk by __

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

Botox Therapeutic (Pain Headaches Migraine) ___ Botox Cosmetic ____

Cosmetic dental smile makeover __

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

Acne	Herpes (or cold sores)	polycystic ovarian syndrome
Arthritis	Hirsutism	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	Melanoma	Allergy to cow's milk protein

Do you use sunscreen? Yes ___ If "Yes" SPF ________ No___

When you sunbathe, how does your skin respond?

Always burn, never tan ___ Sometimes burn, tan about average ___

Usually burn, tan with difficulty ___ Rarely burn, tan easily ___

Almost never burn, tan very easily ___ Never burn, always tan ___

Family Physician ____________________________ Drug Allergies ___________________________

Please list any past illnesses or surgeries:
____

____

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

Do you smoke? _____ How many per day? ______ Weight _______ Height ________

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 or use self-tanning lotions 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: _____________________ DATE SIGNED: ________________________