Medical History

Name: ____ DOB: ____________________

Height: ___________ Weight: __________

Allergies:____

Check the appropriate conditions which you have been treated for

- ☐ Acne
- ☐ Arthritis
- ☐ Autoimmune Disorder
- ☐ Cancer (or radiation therapy)
- ☐ Diabetes/Diabetic neuropathy
- ☐ Herpes (or Cold sores)
- ☐ Hirsutism
- ☐ Hormonal Imbalance
- ☐ Keloid scars/ other scars
- ☐ Kidney disease
- ☐ Local anesthetic sensitivity
- ☐ Melanoma
- ☐ Polycystic ovarian syndrome
- ☐ Port wine stain
- ☐ Psoriasis Steroid or Hormonal therapy
- ☐ Shingles
- ☐ Skin Pigmentation
- ☐ Vitiligo

Please list any illnesses, all minor/major surgeries or conditions not listed above

____

Please list current medications (including aspirin, birth control, herbal remedies', vitamins etc)

____

Do you Smoke Yes/No If so how many per day ________________

Do you suntan, use self-tanning lotions/sprays or tanning beds

If yes please specify how often ____

Do you use sunscreen? Yes / No If "yes" SPF # ________

When you suntan, how does your skin respond

- ☐ Always burn, never tan
- ☐ Usually burn, tan with difficulty
- ☐ Sometimes burn, tan about average
- ☐ Rarely burn, tan easily
- ☐ Almost never burn, tan very easily
- ☐ Never burn, always tan

When was the last time you: Waxed________________ OR Used a depilatory _________________

Have you ever used Accutane? ____

List any products your are currently using on your skin

_____________________________ _____________________________ _____________________________

_____________________________ _____________________________ _____________________________

Do you have any skin sensitivities ____

____

Have you ever been treated by an endocrinologist, dermatologist or plastic surgeon

____

____

Have you ever had "Botox" treatments in the past ____

I am interested in

- ☐ Botox
- ☐ Cosmetic veneers "Dental Smile Makeover"
- ☐ Sharing before and after treatment photos

Are you currently pregnant, breast feeding or do you plan to become pregnant in the next year? Yes/No

Patient Signature: ____ Date: ________________________

Dentist Signature: ____ Date: ________________________