centennialfacial aesthetics

## Medical History

Name: _____ Birthdate (m/d/y): _____Sex: ☐ Male ☐ Female

Address: _____City: _____Province:_____Postal Code: _____

Email: _____

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) _____

☐ Website/Internet ☐ Coupon____ ☐ Magazine_____ ☐ Walk by ☐ Advertisement_____ ☐ Referral_____

**I am interested in:**

☐ Botox Therapeutic (Pain, Headaches, Migraine) ☐ Botox Cosmetic

☐ Hair Removal ☐ Skin Rejuvenation/Wrinkle Reduction ☐ Scar/Acne Scar Reduction

☐ Treatment of Age Spots ☐ Red & Dark Spots ☐ Sun Damage

☐ Acne Control ☐ Tooth Whitening

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

| | | |
|---|---|---|
| ☐ Acne | ☐ Herpes (or cold sores) | ☐ Polycystic ovarian syndrome |
| ☐ Arthritis | ☐ Hirsutism | ☐ Port wine stain |
| ☐ Autoimmune Disorder | ☐ Hormonal Imbalance | ☐ Psoriasis Steroid or Hormone 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 ☐ No If "Yes" SPF _____

**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 _____

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Please list any past illnesses or surgeries:_____

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

_____

Do you smoke? ❑ Yes ❑ No How many per day? _____ Weight _____ Height _____

Are you currently being treated for any conditions not listed? ❑ Yes ❑ No

If yes, please specify_____

Have you ever used (or are currently using) Vitamin A or Glycolic acid? ❑ Yes ❑ No

If yes, please specify _____

Have you ever used (or are currently using) Accutane? ❑ Yes ❑ No

If yes, please specify _____

Have you ever had a chemical peel? ❑ Yes ❑ No

If yes, please specify _____

Have you ever had laser treatment in the past? ❑ Yes ❑ No

If yes, please specify _____

Have you had “Botox” or “Derma Filler “treatments in the past? ❑ Yes ❑ No

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? ❑ Yes ❑ No

If yes, please specify _____

Have you ever been treated by an endocrinologist, dermatologist, plastic surgeon? ❑ Yes ❑ No

If yes, please specify _____

Do you sunbathe, use self-tanning lotion or use tanning beds? ❑ Yes ❑ No

If yes, please how often? _____

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

If yes, please specify _____

Do your gums bleed sometimes or are they ever painful when brushing or flossing? ☐ Yes ☐ No

If yes, please specify _____

Have you had any cavities within the last 3 years? ☐ Yes ☐ No

If yes, please specify _____

Do you have problems with your jaw joints? (pain, popping, clicking) ☐ Yes ☐ No

If yes, please specify _____

Is there anything about the appearance of your mouth (smiles, lips, teeth, gums), that you would like to change (shape, color,size, display)? ☐ Yes ☐ No

If yes, please specify _____

Patient Signature_____ Date Signed _____

Dentist Signature_____ Date Signed _____