Medical History

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? _____

Dr. Corinna Hildebrand & Dr. Raymond Myers
104-1st Street S.W. (Box 5477), High River, AB T1V 1M6
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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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