Botox & Dermal Filler Medical History

106 -175 Chestermere Station Way Chestermere, Alberta T1X 0A4 Phone: 587-349-5850 Fax: 403-235-6209
Email: medspa@lifepathwellness.com Web: www.medspachestermere.com

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

Address: _____ City: _____ State/Province: _____

ZIP/Postal Code:_____ Email: _____
(Re-care appointment times will be confirmed by e-mail)

Phone: (Home) _____ (Work) _____ (Cell) _____

Family Physician: _____ Drug Allergies: _____

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 Cosmetic

☐ Hair Removal

☐ Skin Rejuvenation / Wrinkle reduction

☐ Treatment of age spots / sun damage

☐ Cosmetic Fillers (for lips or deep lines)

☐ Cosmetic 'Dental Smile Makeover' (veneers)

Medical History: Check 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
☐ Epilepsy
☐ Melanoma
☐ Vitiligo
☐ Diabetes/Diabetic neuropathy
☐ Local anesthetic sensitivity

Do you use sunscreen? ☐ Yes, If "Yes" SPF# _____ ☐ No

When you sunbathe, how does your skin respond?

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

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

_____

Do you smoke? ☐ Yes ☐ No How many per day? _____ Weight _____ Height_____

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

_____

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 had laser treatments 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? _____

Have you ever been treated by an endocrinologist, dermatologist, plastic surgeon? ☐ Yes ☐ No If yes, please specify:

_____

Do you sunbathe, use self-tanning lotions / sprays or use tanning beds? ☐ Yes ☐ No If so, please specify 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:

_____

_____ _____

Signature Date