GLENMORE PARK DENTAL
DR. R. PASTERSHANK

MEDICAL HISTORY

Name:_____ Birthdate:_____(mm/dd/yy) Sex: Male___ Female___

Address:_____ City: _____ Province:_____

Postal Code:_____ Email: _____
(Recare 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 __ Treatment of age spots/sun damage __

Hair Removal __ Cosmetic Fillers (for lips or deep lines __

Skin Rejuvenation/Wrinkle reduction __ 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	Hirsutism	Port wine stain
Autoimmune disorder	Hormonal imbalance	Psoriasis
Blood Disorder	Keloid scars/other scars	Shingles
Cancer (or radiation therapy)	Kidney disease	Skin Pigmentation
Diabetes/Diabetic neuropathy	Local anesthetic sensitivity	Steroid or Hormonal Therapy
Epilepsy	Melanoma	Vitiligo

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 ____

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

_____

Do you smoke? _____ 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? 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: _____ DATE SIGNED: _____