Canyon Meadows
Dental Care

11646 Elbow Dr. SW
Calgary, Alberta T2W 1S8
(403) 278 3400 Fax: (403) 278 3458

Medical History

Name: ______________________ Birthdate: ____________ (mm/dd/yyyy) Sex: ☐ Male ☐ Female

Address: ______________________ City: ____________ State/Province: ________

Zip/Postal Code: ____________ Email: ______________________
(We will contact you for your recare by e-mail)

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) ______________________

☐ Newspaper ☐ Website/Internet ☐ Coupon ☐ Yellow Pages ☐ Magazine ☐ Walk by

I am interested in: (Please check all that apply):

☐ Botox Therapeutic (Pain Headaches Migraine) ☐ Botox Cosmetic ☐ Costmetic dental smile makeover

Medical History: Check the appropriate condition for which you have ever been treated:

☐ Acne
☐ Arthritis
☐ Autoimmune disorder
☐ Blood disorder
☐ Cancer (or radiation therapy)
☐ Diabetes/Diabetic neuropathy
☐ Epilepsy
☐ 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
☐ Allergy to cow's milk protein

Do you use sunscreen? ☐ Yes, SPF: ________ ☐ No

When you sunbathe, 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

Family Physician ______________________ Drug Allergies ______________________

Please list any past illnesses or surgeries:

____

____

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

Do you smoke? ☐ Yes. How Many per day? _____ ☐ No Weight ________ Height ________

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 or use self-tanning lotions 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: ________________