PUCKER UP
Dental Spa

Welcome To Our Office

Patient's Full Name:_____
Date of Birth:_____Age:_____
☐ Male ☐Female
Mailing Address_____
_____
City: State: Zip:
Cell Phone Number:_____
Alternate Phone Number:_____
Email:_____
Emergency Contact:_____
Relationship/Phone Number:_____
How did you hear about us:_____
If referred by someone, who can we thank?_____

Medications

Please list all medications which you are currently taking or have used in the past 6 months (be sure to include any of the following: birth control pills, aspirin or ibuprofen containing drugs, weight loss medications, Coumadin or any blood thinning medication, prescription eye drops, steroids)aspirin or ibuprofen containing drugs, weight loss medications, Coumadin or any blood thinning medication, prescription eye drops, steroids)

Name	Strength	Frequency

List ALL ALLERGIES including LATEX:_____

Are you a smoker? YES NO Ex-Smoker? YES NO
If yes, how much are (were) you smoking?_____
How long?_____Quit how long ago?_____
How much alcohol do you drink?_____
Caffeine Use/How much?_____

Please circle any of the following medical conditions you have or have had in the past:

None of the below / Thyroid Disease / Cancer / Bleeding Tendency / Diabetes / Blood Transfusions / Glaucoma / Lung Disease / TB / Asthma or Wheezing / Emphysema / Neurological Disorders / Irregular Heart Beat / Chest Pain / Heart Disease / High Blood Pressure / Heart Attack / Stroke / Epilepsy / Heart Burn / Intestinal Ulcers or Bleeding / Rheumatoid Arthritis / Scleroderma / Lupus / MS Myasthenia Gravis / Raynaud's Syndrome / Porphyria / Depression Mental Illness / Drug or Alcohol Addiction / Hepatitis B / Hepatitis C / HIV / Any other serious illness or injury
Detail of any circled items:_____

When was your last menstrual period (if applicable)?_____
Do you experience vaginal laxity or dryness (if applicable)? YES NO
Do you experience stress incontinence? YES NO
Do you have a history of herpes simplex (cold sores)? YES NO
Last Outbreak?_____
Does your skin ever flake or feel tight and dry?
Frequently Occasionally Very Rarely
What skin care products are you currently using?_____
_____
When did you last tan or use a tanning bed?_____
What would you like to see changed about your skin?
_____

YES/NO Are you pregnant or lactating?
YES/NO Do you have a history of developing keloids (raised scars)?
YES/NO Have you ever been diagnosed with Vitiligo (skin pigment loss)?
YES/NO Have you ever seen a dermatologist for your skin?
If so, what for?_____
YES/NO Do you or have you used any topical medications?
If so, which?_____
YES/NO Have you ever had unusual reactions to topical numbing cream?
YES/NO Do you use any form of Retin-A, Glycolic Acid or Salicylic Acid?
YES/NO Have you ever been on Accutane? If so, how long?_____
YES/NO Have you ever had Botox or Dermal Filler injections? If so, how long ago?_____
YES/NO Have you ever had a bad reaction to any skin care products?
YES/NO Have you ever had a chemical peel? If so, any adverse reactions?
_____
YES/NO Do you use sunscreen?
YES/NO Do you wax or use depilatories on your face? If so, when was the last time?_____
YES/NO Do you have a history of atypical moles, melanoma or skin cancer in yourself or family?
YES/NO Does your skin get oily a few hours after cleansing?
YES/NO Do you have a history of acne or periodic breakouts?

Which of the following describes your skin? Please circle one.

I Always burns, never tans
II Always burns, sometimes tans
III Sometimes burns, always tans
IV Rarely burns, always tans
V Brown, moderately pigmented skin
VI Black skin

List all surgeries (including plastic surgery) and Date:
_____
_____
_____

I acknowledge that I have disclosed my complete medical history and the above is a complete and accurate representation of my medical and skin status.

Signature_____Date:_____