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Synergycentre
Dental & Healthcare

Dermatology / Cosmetic Mole Removal / Lesion Removal - INTAKE

Welcome to the office of Dr. Maria Tetelbaum. Located within Synergy Centre Dental & Healthcare.
In order to provide you with the most appropriate and safe treatment, we need you to complete the following questionnaire. All information is strictly confidential and for our records only.

PERSONAL HISTORY

Date: _____

Last Name: _____ **First Name:** _____

Date of Birth: D _____ M _____ YR _____ **Age**: _____

Address: _____ City/Town:_____ Postal Code: _____

Telephone: (_____) _____ May we leave a voicemail? **YES / NO**

***Email:** _____ Occupation: _____

OHIP (health card) #: _____ Version Code: _____

How did you hear about us? (*please circle)*

Friend or Family Facebook/Instagram Website Magazine/Flyer Physician/Healthcare Professional

Signage on building/Driving by Google Search Other: _____

MEDICAL HISTORY

Family Physician: _____ Address: _____

Are you currently pregnant or planning a **pregnancy** within the next year? **YES / NO**

Major Illnesses or Surgeries [PAST or PRESENT] (cancer, diabetes, surgery, etc.) _____

Do you have any **neurological** conditions?
[i.e. myasthenia gravis, multiple sclerosis, ALS, Lambert-Eaton syndrome, etc.] **YES / NO**

Have you ever had **Bells Palsy?** **YES / NO** If yes, when? _____

Do you have any **autoimmune** conditions? [i.e. lupus, psoriasis, rheumatoid arthritis, Crohn's disease, etc.] **YES / NO**

Are you awaiting any surgery/procedure? [eg. joint replacement, colonoscopy, dental implant/cleaning, etc.] **YES / NO**
If yes, please explain:
_____

Please list any **current medications** including prescriptions, over-the-counter, vitamins, herbal supplements (including dosage):
_____
_____

Current health conditions/diagnoses (*if not already listed*):
_____
_____

Please list any **Allergies** [foods, medication, bee/wasp stings]: _____

Allergic reaction or sensitivity to Lidocaine? [dental freezing]: **YES / NO**

Have you ever had an **anaphylactic** allergic reaction? **YES / NO** If yes, to what? _____

Are you taking **blood thinners** [anti-coagulant or anti-platelet medications]? **YES / NO** If yes, please explain: _____

Have you taken Aspirin, Advil, alcohol in the **last 48 hours**? **YES / NO**

Do you smoke cigarettes? **YES / NO** (_____ per day) Do you use recreational drugs? **YES / NO**

SKIN HEALTH & HISTORY

How would you rate the quality of your skin? *(circle)* Poor Fair Good Very Good Excellent

Do you have a history of **keloid** (thick) scarring? **YES / NO**

Do you have a history of hyper-pigmentation? **YES / NO**

Do you have a history facial ***Herpes Simplex*** (cold sores)? **YES / NO** If yes, date of last outbreak: _____

Do you regularly sun bathe or use tanning beds? **YES / NO** If yes, how often? _____

Do you use SPF/sunscreen/sunblock? **YES / NO**

Do you use any Retinol based products? **YES / NO**

What is the reason for your visit with us today? _____

Please check any skin concerns you would like to have addressed today:

[ ] Aging / Wrinkles
[ ] Dryness
[ ] Sun damage
[ ] Acne / Acne Scarring
[ ] Sensitive
[ ] Melasma (dark spots)
[ ] Rosacea
[ ] Moles/Lesions
[ ] Other (please describe): _____

If you are interested in **cosmetic mole removal or lesion removal,** please describe where it is located:

_____

_____

REQUIRED: **I acknowledge that I have read, understood and answered the above questions related to my health and medical history to the best of my knowledge.**

Patient Name: _____ Date: _____

Patient Signature: _____