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BEAUTY WITHIN
MEDICAL AESTHETICS • SYNERGY CENTRE

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www.beautywithin.ca

Welcome to the office of Dr. Maria Tetelbaum at **Beauty Within (Medical Aesthetics)**
(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? _____

Do you suffer from seasonal / environmental allergies? **YES / NO** Do you suffer from chronic sinus congestion? **YES / NO**

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**

Have you lost significant weight in the last year? [more than 30 lbs] **YES / NO** If yes, please explain: _____

Have you been diagnosed with osteoporosis ? **YES / NO**

Have you lost any posterior [back] teeth [molars]? **YES / NO** (R side / L side) Any history of gum disease? **YES / NO**

SKIN HEALTH & HISTORY

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

If you could improve your skin, what would focus on? *(circle)* Hydration Elasticity/Tightness Smoothness/Texture Acne

Volume Redness Scarring Pigmentation

OTHER (eg. mole removal, etc): _____

Have you had any **facial surgeries/procedures?** (i.e. facelift, rhinoplasty, blepharoplasty, skin cancer removal, etc)
If so, what?

_____

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

Do you have a history of hyper-pigmentation/melasma? **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 do you currently use for skincare? *(i.e. soap, cleanser, toner, serum, moisturizer, pharmaceutical grade or drugstore)*

_____

COSMETIC TREATMENT HISTORY

Have you previously received cosmetic injection treatments? YES / NO

If yes, please indicate if it was: **Botox** (Date of last injection: _____)

Dermal Fillers (Date of last injection: _____)

Other (i.e. PRP, micro-needling, threads, etc): _____

*Any **concerns or complications** from previous treatments? **YES / NO** If yes, please explain: _____

****You may NOT have Botox, Dermal Fillers or PRP Therapy if you are pregnant, breastfeeding, or during the first 3 months following delivery.****

What is the main reason for your visit with us?

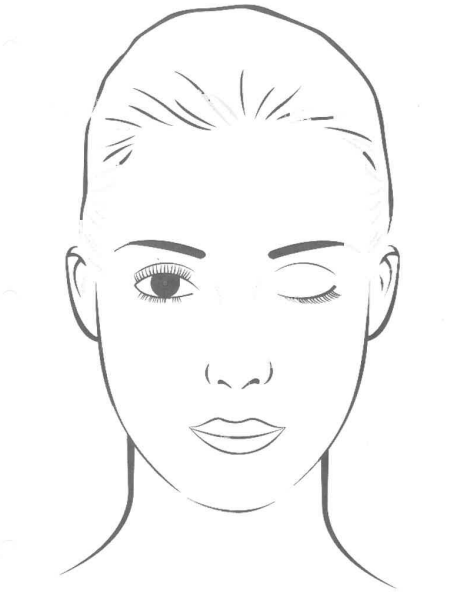
_____

_____

What are the 3 main areas you wish to treat?

1. _____
2. _____
3. _____

Please circle the area(s) of your interest



Which 3 statements best reflect how you feel about your appearance?
(List in order #1 - #2 - #3)

___ I want to look less tired
___ I want to look less angry
___ I want to look less sad
___ I want a less saggy appearance
___ I want to look more youthful
___ I want to look more attractive
___ I want my face to look slimmer
___ I want to improve my chin profile [double chin]
___ I want softer features

OPTIONAL *Circle any of the treatments below that may also be of interest to you.

FACIAL IMPROVEMENT	SKIN QUALITY	DENTAL	OTHER
Dermal Fillers [**Juvederm**®]	Skin Injections [**Juvederm**® Volite]	**ZOOM** Teeth Whitening	**Botox**® Treatment for **Chronic Migraine** or **Hyperhidrosis** (excessive sweating)
Wrinkle Relaxers [**Botox Cosmetic**®]	Skincare Products [**Vivier**® line]	**INVISALIGN** Teeth Straightening / Braces	**Latisse**® Grow your own eyelashes!
Non-Surgical Facelift [**MD Codes** facelift]	Laser Treatment [for hyperpigmentation, rosacea, skin tightening]	**Cosmetic Dentistry** Veneers	**PRP** [Platelet Rich Plasma] Treatment for **Hair Loss**
[**Belkyra**®] Under chin fat reduction	Chemical Peels	Dental implants	Laser Hair Removal
PRP [Platelet Rich Plasma] with micro-needling for Face, Neck, Décolleté	Facials	TMJ Treatment [jaw clenching]	Laser Tattoo Removal
Cosmetic Mole Removal	Microdermabrasion		Microblading [eyebrows]
Cryotherapy [freezing] for age spots	Micro-Needling with Hyaluronic Acid		Eyelash Extensions

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: _____