CARING WAY ESTHETICS
OF PORT CHARLOTTE

Caring Way Dentistry | Caring Way Esthetics
(941) 627-9900
caringwayesthetics.com
caringwaydentistry.com

Medical History

Name ____________________ Address ____________________

City __________ State __________ Zip __________ Email ____________________

Home Phone ____________________ Work/Cell Phone ____________________

Primary Physicians Name ____________________ Phone ____________________

DOB __________ Age __________ Height __________ Weight __________

Please list any medications/vitamins you are currently taking: ____________________

____

Allergies: ____________________ Are you on antibiotics at this time? ____________________

Do you have any of the following conditions? (Check Yes or No)

YES	NO		YES	NO	
☐	☐	Cold Sores, when? __________	☐	☐	Diabetes?
☐	☐	Dry Eye, Use drops? __________	☐	☐	Use of Tobacco Products?
☐	☐	Abnormal Heart Condition __________	☐	☐	Cosmetic Surgeries?
☐	☐	High / Low Blood Pressure (Circle) __________	☐	☐	Facial Cosmetic Surgery?
☐	☐	Fainting Dizzy Spills? __________	☐	☐	Pregnant, or Nursing?
☐	☐	Prolonged Bleeding, why? __________			

List and/or Explain Other Medical Conditions not listed above: ____________________

____

Have you ever had Plastic Surgery or other surgery to your face/neck areas? If so, when? __________

____

Have you ever had any type of Laser, Botox, Dermal Filler (Restylane, Radiesse, Sculptra, Juvederm), performed on your face or have scheduled in the future? ___________________________________

____

If so, what procedures? Where on your face? ______________________________________

____

When performed or scheduled? ____

Were you pleased with your results? Any concerns? __________________________________

____

How did you hear about Caring Way Esthetics? _______________________________________

I understand the information on this form is essential to determine my medical and cosmetic needs and the provision of treatment. I understand that if any changes occur in my medical history/health I will report it to the office as soon as possible. I have read and understand the above medical history questionnaire. I ackowledge that all answers have been recorded truthfully and will not hold any staff member responsible for any errors or omissions that I have made in the completion of this form.

_______________________________ _______________________

Patient Signature Date