

This is not for disclosure



SKIN MEDICAL FORM

Your answers on this form will help us provide you with the safest and best dental care. If you have any questions your dentist will be glad to help. **Thank you!**

Title: Mr/ Mrs / Miss / Ms / Dr

Surname:

Forename:

Address:

Postcode:

Date of Birth:

Email:

Home & mobile number:

Work number:

Do you suffer from any of the following medical conditions?

Cancer
Diabetes
Epilepsy
Rosacea

Hepatitis C / any blood diseases
Cold sores / herpes simplex virus
Shingles
Lupus

Do you have allergies to any of the following?

Latex Aspirin Onion Apple Alcohol Acetone Salicylic Acid Willow Bark
Potassium nitrate

Do you have any other allergies?

Do you or have you used any of the following on your skin:

Retin-A Roaccutane any other Acne treatment (Topical/oray)

Details:

Have you has laser resurfacing, facial plastic surgery or any other skin treatments in the last 6 months?

Yes No

Details:

Which product line do you use on your skin?

What are your main skin concerns / what do you want to improve about your skin?

Details:

Signature of patient / parent / guardian:

Date:

Signature of examining clinician:

Date: