## Patient Information/Medical History

Date:

Name:

Address:

City:

State:

Zip Code:

Cell Phone #: Alternate Phone #:

Email Address:

 \*\*Do you wish to receive emails or texts from this office regarding special promotions from the practice or product

 manufacturers on injectables? No: Yes \_\_\_\_\_\_

Date of Birth: Age: Sex:

Marital Status: Name of Spouse:

Occupation/Employer:

In case of emergency, contact: Cell Phone #:

## Health Questionnaire

YOUR HISTORY: Check All Current or Past Medical Conditions:

Allergies Autoimmune Disease Bladder/Kidney Cancer

Diabetes

Eczema/Skin Issues Epilepsy/Seizures

Excessive Bleeding Headaches

Heart Disease

Herpes or Cold Sores High Blood Pressure HIV/AIDS

Neuromuscular Disease/Stroke

Sinus Infections

Swallowing Issues Thyroid Disorder TMJ/Jaw Dysfunction

Other:

Are you Pregnant? Nursing?

Surgery/Hospitalizations Reason Year/Age

|  |  |  |
| --- | --- | --- |
|  |  |  |
|  |  |  |
|  |  |  |

 List Current Prescription Medications (within the last 2 weeks)

1. 2.
2. 4.

Current Supplements, Vitamins or Over-The-Counter Items; Including ADVIL, MOTRIN, ASPIRIN or ALEVE:

1.

2.

3.

4.

List known Allergies to either Food or Drugs:

Circle the Items That You Use and Indicate How Much and How Often:

Caffeine: Alcohol:

Cigarettes: Illegal Drugs:

*I AGREE THAT THE ABOVE INFORMATION IS CORRECT AND CURRENT TO THE BEST OF MY KNOWLEDGE.*

Signature: Print Name:

Date:

# **Important Inquiry for Botox® Cosmetic Treatment:**

**History:**

Are you suffering from a skin infection/disease at the proposed injection site(s)? Do you have a history of cold sores?

Do you have a history of any bleeding disorders? Do you have a history of heart disease?

Could you be or are you currently pregnant/breastfeeding? Have you had Botox Cosmetic in the past?

If yes, what was the last treatment date: Have you ever had an adverse reaction to Botox Cosmetic?

Do You or Any Family Members Have a History of the Following

Amyotrophic Lateral Sclerosis Motor Neuropathy Myasthenia Gravis

Lambert-Eaton Syndrome Facial nerve (Bells) Palsy

YES NO

Signature:

Print Name:

Date: