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MEDICAL HISTORY

□BOTOX/DYSPORT/Xeomin □Dermal Fillers

Name_____DOB_____Ht_____Wgt_____Date_____

Address_____City_____State_____Zip_____

Home Phone_____Work/Cell Phone_____Email:_____

Primary Physician's Name and Number_____

Please list all medications you are currently taking:

_____

List Vitamin Supplements you are taking:

_____

List any Allergies: _____

Circle any of the following you have or have ever had in the past:
Multiple Severe Allergies/Hypersensitivity to medications - Sensitivity/Allergy to Lidocaine – HIV/Autoimmune Disease/ History of Cold Sores - Allergy to Beef /Dairy/Cow's Milk Products – Lupus - Keloid Formation - Myasthenia Gravis Hepatitis - Eye Disease - Vision Problems - Numbness - Muscle Weakness - Multiple Sclerosis Amyotrophic Lateral Sclerosis (ALS) - Parkinson's Disease - Neurological Disorders - Lambert-Eaton Syndrome
List any OTHER MEDICAL or SURGICAL CONDITIONS not listed above that you currently have or have had in past:

_____

WOMEN: Are you Pregnant, Trying to get Pregnant, or Lactating (Nursing)?

_____

Have you had Plastic Surgery or other surgery to your face/neck areas & when?

_____

Have you had any Dermal Filler procedures before? _____If yes, what filler was used and were you satisfied with the results?

_____

Have you had Botox®/Dysport/Xeomin injections before? _____Last treatment? _____What Areas? _____ Were you happy with previous Botox® treatments? _____

Explain_____

Have you ever had eyelid/eyebrow droop after Botox®? _____ Do you show a lot of upper eye lid when eyes are open? _____ Do your eyelids feel extra heavy when you don't get enough sleep?

_____

Do your eyelids droop without sleep? _____ Areas of special concern to patient?

_____

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 acknowledge 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_____

Practitioner Signature_____Date_____