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BOTULINUM TOXIN A MEDICAL HISTORY

Welcome To Our Practice! In Order To Properly Serve You, Please Complete The Following Forms In Their Entirety.

Date: ________________________

Last Name: ________________________________**First Name:** _______________________________**Middle:** _________

Address: ____

City: ____**State:** __________ **ZIP:** ____________________

Gender: **Male / Female** **DOB:** _____________________

Phone – Home: ________________________ **Work:** _____________________________ **Cell:** ______________________

E-Mail: ____

Emergency Contact: ____ **Phone:** _____________________________

Current Physician: ____ **Phone:** _____________________________

LMP: _______________________ **Are you pregnant, trying to get pregnant, or lactating?** _________________

Are you allergic to any medications? _______ **YES** _______ **NO**

If YES, What medication(s) ____ **Reaction:** ___________________________

Please list all medications you are currently taking including any over-the-counter medications:
Please do not leave any blanks. Enter N/A if necessary.

Medication	Condition	Medication	Condition

Please list any Hospitalizations or previous operations. Please do not leave any blanks. Enter N/A if necessary.

Surgery/Operation	Date (If Known)	Other Hospitalizations	Date (If Known)

Do you have or have you had any of the following illnesses? Please do not leave any blanks. Enter N/A if necessary.

Myasthenia Gravis	Eye Disease	Numbness	Neurological Disorders
Hepatitis	Vision problems	Muscle Weakness	Lambert-Eaton Synd.
Autoimmune Disease	Parkinson's Disease	Multiple Sclerosis	ALS

Have you had plastic surgery or other surgery to your face/neck area? _______________ **If YES, When?** ________________
Have you had Botulinum Toxin A injections before? __________ **Last Treatment:** ___________ **Area:** _________________
Were you satisfied with previous Botulinum Toxin A treatments? ___________ **YES** ________________ **NO**
Explain: ____
Have you ever had eyelid/eyebrow droop after Botulinum Toxin A? ____________ **YES** ___________ **NO**
Do you show a lot of upper eyelid when eyes are open? _____________ **YES** ____________ **NO**
Do your eyelids feel extra heavy when you don't get enough sleep? _________ **YES** _________ **NO**
Do your eyelids droop without sleep? _____________ **YES** ______________**NO**

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 or 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:** ____________________________