
# Medical History:

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip:_____

Phone: _____ Work/Cell: _____

Email: _____

Primary Physicians Name: _____ Phone: _____

List of Medications you are currently taking:

_____

_____

Are you taking Coumadin, Warfarin, Xarelto, or any other blood thinners?

_____

Allergies to any medications?

_____

Are you currently taking any antibiotics?

_____

Circle any of the following illnesses you have or have ever had in the past:

Myasthenia Gravis  Hepatitis  Eye Disease  Autoimmune Disease

Vision Problems  Numbness  Muscle Weakness  Multiple Sclerosis

Other Neurological Disorders? yes ☐ no ☐

List and explain any other medical conditions not listed above:

_____

_____

_____

Previous Hospitalizations:

Surgeries: _____

WOMEN: Are you pregnant, trying to get pregnant, or lactating?

_____

Have you ever had any type of Plastic Surgery or other surgeries to your face and neck areas? If so, when?

_____

Have you had Botox injections before? _____

Last treatment? _____

Have you had Dermal Fillers before? _____

Last treatment? _____

Were you happy with previous Botox and Filler Treatments?

_____

Explain

_____

_____

Do your eyelids look heavy when you do not get enough sleep?

_____

Have you ever had eyelid/eyebrow droop after Botox? _____

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 medical changes occur in my history/health, that 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 I will not hold any staff members responsible for any errors or omissions I have made when completing this form.

Patient Signature: _____ Date: _____