EXCLUSIVE WELLNESS & AESTHETICS
BOTOX MEDICAL HISTORY

Name____________________________________**Address**____
City______________________________**State**__________**Zip**_____________**Email**_______________________
Home Phone______________________________ **Work/Cell Phone**_________________________________
Primary Physician's Name__________________________________ **Phone #**_______________________
B/P______________**T**_______**P**_____**R**____**DOB**________________ **Age**______ **Ht**____________ **Wt**_______

Please list all medications you are currently taking:____
____
Allergies: _________________________ **Are you on Antibiotics at this time?**________________________

Circle any of the following illnesses you have or have ever had in the past:
Myesthenia Gravis Hepatitis Eye Disease Autoimmune Disease Vision Problems
Numbness Muscle Weakness Multiple Sclerosis Amyotrophic Lateral Sclerosis (ALS)
Parkinson's Disease Neurological Disorders Lambert-Eaton Syndrome

List and/or Explain Other Medical Conditions not listed above:____
____
PreviousHospitalizations/Operations:____
____
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?___________________
____
Had Botox® 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**________________________

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