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BOTOX AND DERMAL FILLER PATIENT MEDICAL HISTORY

Name _____
Phone _____Age _____Ht _____Wt_____
Address_____
City/State_____Zip_____

PAST MEDICAL HISTORY (please include any current health problems)**:**

_____
_____
_____

MEDICATIONS (please include herbal supplements)**:**

_____
_____

ALLERGIES:

_____

Are you (or could you be) pregnant or breast feeding?_____

Previous Medical/Aesthetic surgery (including dermal fillers, botox, lasers etc.) or previous facial/eyelid surgery:

_____
_____

Previous Dermal Filler □ Yes □ No Date: _____

Complications: □ Yes □ No Date: _____

Type of Dermal Fillers: _____

Previous Botox □ Yes □ No Date: _____

Complications: □ Yes □ No Date: _____

Do you have or have you ever had in the past:

Hypersensitivity to Botulinum A toxin products	□ Yes	□ No
History of allergy to latex, lidocaine, human albumin or eggs	□ Yes	□ No
History of multiple, severe allergies or anaphylactic shock	□ Yes	□ No
Autoimmune disease	□ Yes	□ No
HIV	□ Yes	□ No
Active skin condition (e.g. eczema, rosacea, psoriasis)	□ Yes	□ No
History of cold sores (oral Herpes)	□ Yes	□ No
Infection at the proposed injection site(s)	□ Yes	□ No
Bleeding Disorders	□ Yes	□ No
History of prior surgery at proposed injection site(s)	□ Yes	□ No
History of tobacco use	□ Yes	□ No

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History of regular sun exposure/use or tanning beds	□ Yes	□ No
History of keloid scarring	□ Yes	□ No

Do you or a family member have:

Amyotrophic Lateral Sclerosis (ALS)	□ Yes	□ No
Motor Neuropathy or muscle weakness	□ Yes	□ No
Myasthenia Gravis	□ Yes	□ No
Eaton-Lambert Syndrome	□ Yes	□ No
Facial Nerve Palsy	□ Yes	□ No
Numbness	□ Yes	□ No
Neurologic disease	□ Yes	□ No
Vision problems or eye disease	□ Yes	□ No

Do you take or have you recently been on any of the following medications:

Warfarin or Anti-Platelet Agents (list any anti-coagulants)	□ Yes	□ No
Aspirin	□ Yes	□ No
Anti-inflammatories, steroids, or non-steroidals (Advil, Aleve, Celebrex)	□ Yes	□ No
Immunosuppressive therapy	□ Yes	□ No
Quinidine	□ Yes	□ No
Aminoglycosides	□ Yes	□ No
Cyclosporine	□ Yes	□ No
Aminoquinolones	□ Yes	□ No
Penicillamine	□ Yes	□ No
Anticholinesterases	□ Yes	□ No
Muscle relaxants	□ Yes	□ No
Calcium channel blockers	□ Yes	□ No
Anti-depressant medications	□ Yes	□ No
Ginko Biloba	□ Yes	□ No
Vitamin E	□ Yes	□ No
Garlic	□ Yes	□ No
Flax seed	□ Yes	□ No
Any antibiotics not listed above (please list)	□ Yes	□ No

Do you have:

Skin infection at site of injection	□ Yes	□ No
Evidence of muscular atrophy	□ Yes	□ No
Evidence of petechia or bruising	□ Yes	□ No
Facial Asymmetry	□ Yes	□ No
Ptosis	□ Yes	□ No
Deep dermal scarring	□ Yes	□ No
Dermatochalasis (excessive redundant eyelid skin)	□ Yes	□ No
Dry Eye	□ Yes	□ No

(If you answered Yes to any one of the above, please explain below)

_____

_____

_____

Are you a member of the ASPIRE Galderma Rewards, or XPERIENCE Merz Program? If not, ask us for details on how to sign up.

If yes, please provide us with your member number: _____

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 questionnaire. I acknowledge that all answers have been recorded truthfully and to the best of my knowledge and I 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

_____ _____

Physician Signature Date