PLEASE COMPLETE ALL AREAS OF THIS FORM FOR YOUR PROVIDER

PATIENT INFORMATION/MEDICAL HISTORY

Name:____ Date:__________________

Date of Birth:_______________ Age:_____ Sex: M or F Marital Status:______________

Address:____
Street City State Zip Code

Phone: (home)_________________ (work)_________________ (cell)__________________

Email address:____

Preferred phone number to contact you: Home / Work / Cell (Please circle one)

May we leave a voicemail at this number to confirm appointments?___________________

Employer:______________________________ Occupation:___________________________

Emergency Contact:_________________________________ Relationship:_______________

Phone: (home)_________________ (work)_________________ (cell)__________________

Primary Care Physician:__________________________________ Phone:_______________

How did you hear about us? :____

HEALTH HISTORY

Medications (prescription, over-the-counter, vitamins, herbal supplements)

___________________________________ ___________________________________

___________________________________ ___________________________________

___________________________________ ___________________________________

___________________________________ ___________________________________

___________________________________ ___________________________________

___________________________________ ___________________________________

PLEASE COMPLETE AND SIGN THE BACK OF THIS FORM

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Allergies:

Have you ever been diagnosed with an allergy to any of the following: (Please answer yes or no)
Lidocaine, gluteraldehyde, gram positive bacterias, glycerin, or sodium carboxymethylcellulose _____
If yes, which substance: ______________________________

Surgeries/Dates:

Medical History: (*PLEASE MARK BOXES THAT APPLY TO YOU*)

Neuro/Muscular disorders	☐	Seizures	☐
High blood pressure	☐	Heart disease	☐
Bleeding tendencies	☐	Diabetes	☐
Cancer	☐	Shingles	☐
Emphysema	☐	Excessive sweating	☐
Ulcers	☐	Asthma	☐
Lupus	☐	Stroke	☐
Myasthenia	☐	Colitis	☐
Gravis	☐	Anemia	☐
Keloid formation	☐	Gout	☐
Kidney disease	☐	Cold Sores	☐
Tuberculosis	☐	Migraines	☐

Any other serious illness: ______________________________

Are you pregnant? ______________ Nursing? ______________

Past or present use of:

Tobacco: _____ Current use/Packs per day: _____ If quit, when: ____
Alcohol: _____ Amount per day/week: ______________

Have you had prior treatment with: botulinum toxin (Botox Cosmetic) Yes / No
Have you had prior treatment with: dermal tissue fillers (Juvederm/Restylane) Yes / No
Did you have any problems with these injections? Yes / No
If yes, plese explain: ______________________________

I have answered all questions to the best of my knowledge ______________________
Print name

______________________ ______________________
Patient Signature Provider Signature