201 NW 82nd Ave, Suite 104
Plantation, FL 33324
Phone: 954.472.2201
Fax: 954.472.2501

BOTOX® MEDICAL HISTORY

Name ____ Date ______________________

Address ____

City ____________________________ State ______________ Zip _______________

Home Phone ______________________ Work/Cell Phone _______________________

Primary Physician's Name and Number _______________________________________

____

B/P ________ T _______ P _____ R_____ DOB ______ Age _____ Ht _____ Wt_____

Please list all medications you are currently taking: _______________________________
____

List any 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: ______________________
____

Previous Hospitalizations/ 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?____________
____

Happy with the previous Botox® treatments? Explain______________________________
____

Ever had eyelid/eyebrow dropping after Botox®? Explain__________________________
____

Have you ever been called sleep eyes, bedroom eyes? Explain______________________
____

Do you show a lot of upper eyelid when eyes are open? Explain_____________________
____

Do your eyelids feel extra heavy when you don't get enough sleep? Explain____________
____

Do your eyelids droop without sleep? Explain___________________________________
____

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 ___________________________