HEALTH HISTORY FORM

For Injectables

Date___/___/___ Home # _____ Work # _____Pharmacy # _____

Name _____ DOB ___/___/___ Age _____ Male/Female

Address _____ City _____ State ____ Zip _____

Email _____

Employer _____ Occupation _____ S M W D

How were you referred? _____

Medical History

Have you ever been treated for any of the following conditions?

- ☐ Allergy to botulinum toxin
- ☐ Acne
- ☐ Blood disorders
- ☐ Burns/ skins grafts
- ☐ Steroid/Hormone therapy
- ☐ Cancer (radiation/chemo)
- ☐ Diabetes
- ☐ Herpes (cold sores)
- ☐ Depression
- ☐ Swallowing problems
- ☐ Alcoholism
- ☐ Drug abuse
- ☐ HIV
- ☐ Melanoma
- ☐ Keloid formation
- ☐ Kidney Disease
- ☐ High Blood Pressure
- ☐ Lou Gehriq's Disease
- ☐ Shingles
- ☐ Skin Pigmentation
- ☐ Myasthenia gravis
- ☐ Anxiety
- ☐ Muscle weakness
- ☐ Bleeding problems
- ☐ ALS
- ☐ Lambert Eaton Syndrome

Allergies: _____

If your answer if yes to any of the following questions, please explain.

Are you being treated for any other chronic medical condition? _____.

Are you currently taking any medications? (Including Aspirin, Ibuprophen, Advil, etc.?)

_____.

How much alcohol do you drink? daily_____ weekly _____

Have you ever been treated with any fillers? _____.

Do you have facial implants? _____.

Do you have any skin sensitivity? _____.

Have you had surgery performed in the last 6 months? _____.

Are you currently breastfeeding? _____.

Are you currently pregnant or trying to conceive? _____.

Have you ever been treated with Botox or other neurotoxin? _____.

Please list you Primary Care Physician's name, address and phone number:

_____

_____

Please sign below to indicate all the information on this form is accurate and complete.

_____ Date ___/___/___
Patient signature

_____ Date ___/___/___
Witness/ Technician signature

Notes:

_____

_____

_____