Botox Cosmetic/ (Xeomin) Medical History

Name____________________________________DOB:_________________

Address____
City______________________________State__________Zip_______________

Email_______________________ Home/Cell
Phone_______________________________

Primary Physician's Name____________________________________ Phone #________________________

Please list all medications you are currently taking:
____

Allergies: ____

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

Allergies to Human Albumin or Bovine (Cow's Milk)?________________________

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/where?____
____

Had Botox® injections before? _______ Last treatment? _________What Areas?_________________________

Were you happy with previous Botox®(Xeomin) treatments?_______
Explain____
____

Have you ever had eyelid/eyebrow droop after Botox®(Xeomin)?____

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___________________