Palm Beach
PREVENTIVE MEDICINE

A Balanced Approach to Your Health.

Botox Cosmetic™ Medical History

Today's date: _____

Patient Name: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work/Cell: _____ Email: _____

Primary Physician Name: _____ Phone: _____

Age: _____ Ht. _____ Wt. _____ B/P: _____ T: _____ P: _____ R: _____

List all prescription and OTC medications, herbal/natural supplements, or topicals you are currently taking: _____

List allergies: _____

Are you currently taking Antibiotics? YES | NO

Check any of the following illnesses you have or have ever had in the past:

☐ Myesthenia Gravis ☐ Hepatitis ☐ Eye Disease ☐ Autoimmune Disease ☐ Vision Problems

☐ Neurological Disorders ☐ Numbness ☐ Multiple Sclerosis ☐ Parkinson's Disease ☐ Muscle Weakness

☐ Lambert-Eaton Syndrome ☐ Amyotrophic Lateral Sclerosis (ALS)

List and Explain Other Medical Conditions not listed above: _____

Previous Hospitalizations/Operations: _____

Are you pregnant or lactating (nursing)? [YES] [NO] If yes, you are not a candidate for treatment at this time!

Are you trying to get pregnant? [YES] [NO] If yes, a pregnancy test is needed before treatment (results) _____

Do you have a history of cold sores? [YES] [NO]

Have you taken anticoagulants (including Coumadin, Pradaxa, Xarelto, Heparin, Lovenox) in the last 6 months? [YES] [NO]

If Yes, what? _____

Have you had Plastic Surgery or other surgery to your face/neck area? [YES] [NO] If so, when? _____

Had Botox® injections (or Dysport, Xeomin, Myobloc) before? [YES] [NO] Last treatment date? _____

What Areas/Explain? _____

Were you happy with previous Botox® treatments? [YES] [NO] Have you had eyelid/eyebrow droop after Botox®? [YES] [NO]

Do you show a lot of upper eye lid when eyes are open? [YES] [NO] Do your eyelids droop without sleep? [YES] [NO]

Do your eyelids feel extra heavy when you don't get enough sleep? [YES] [NO]

Any areas of special concern? _____

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_____