

BOTOX MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Best Phone #: _____

Address: _____ Date of Birth: _____ Age: _____

_____ Sex: M / F

Emergency Contact: _____

Purpose of your visit: _____

Are you allergic to any medicines, food or OTC products? NO YES

Which? _____

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Do you consume; Tobacco? NO YES How much? _____

Alcohol? NO YES How much? _____

Are you or could you be pregnant? NO YES Last Menses: _____

Do you suffer any Medical problems like:

Convulsions, Face paralysis, Nervous disorders? NO YES Explain: _____

Eye disorders, Glaucoma, etc.? NO YES Explain: _____

Lung problems, Asthma, COPD, etc.? NO YES Explain: _____

Heart attacks, Angina, Blackouts? NO YES Explain: _____

Ulcers, Reflux, Heartburn, etc.? NO YES Explain: _____

Hepatitis, Liver disorders, etc.? NO YES

Explain: _____

Anemia, Bleeding problems Leukemia, etc.? NO YES Explain: _____

Are you taking any Daily Medicines? NO YES

Which: _____

Anything else you wish to add? _____

Signed: _____ Date: _____