BOTULINUM TOXIN "A" MEDICAL HISTORY

Name_____ DOB:_____

Email_____ Phone #:_____

_____

ADDRESS CITY STATE ZIP

Primary Physician's Name_____ Phone #_____

Please answer each of the following questions:

1. Do you have ANY allergies to medications, foods, latex, or other substances? Please List: _____

2. Do you smoke? YES / NO Average per day/week? _____
   Do you consume alcohol? YES / NO Average per day/week? _____

3. Do you have ANY current or chronic medical conditions? YES / NO
Disclose any history of heat urticaria, diabetes, autoimmune disorder or any immunosuppression, blood disorders, cancer, bacterial or viral infections, medical conditions that significantly compromise the healing response, skin photosensitivity disorders, or any other condition or illness.
Please List: _____

4. Do you have ANY current or chronic skin conditions? YES / NO
Also disclose any history of vitiligo, eczema, melasma, psoriasis, allergic dermatitis, any diseases affecting collagen including Ehlers-Danlos syndrome, scleroderma, skin cancer, or any other skin condition.
Please List: _____

5. Are you under a doctor's care? YES / NO
If so, for what? _____

6. Do you take ANY medications (prescriptions or non-prescriptions) including vitamins and herbal supplements on a regular basis? YES / NO
Please List: _____

7. Are there any topical products (both medical and non-medical) that you use on your skin on a regular or daily basis? YES / NO
Please List: _____

8. Are you taking oral steroids (eg. prednisone, dexamethasone)? YES / NO

9. Do you have a pacemaker or external defibrillator? YES / NO

10. Do you have any metal implants under the area being treated? YES / NO

11. Do you have a history of light-induced seizures? YES / NO

12. Do you have a history of Herpes in the area being treated? YES / NO

13. Do you have any open sores or lesions? YES / NO

14. Have you had radiation therapy in the area being treated? YES / NO

15. Do you have a history of keloid scaring or hypertrophic scar formation? YES / NO

16. In the last 6 months, have you used any of the following? YES / NO
Anticoagulants or blood-thinning medications, photosensitizing medications or anti-inflammatories?
List Product, Date Used: _____

17. In the last 3 months, have you used any of the following products: YES / NO
glycolic acid or other alphahydroxy- or betahydroxyacid products, exfoliating or resurfacing products or treatments?
List Product, Date Used: _____

18. Have you had any cosmetic procedures in the past 6 months? YES / NO
Please Describe:_____

19. Have you had any permanent make-up, tattoos, implants, or fillers, including but not limited to YES / NO
collagen, autologous fat, Restylane, ect.? If yes, please list locations and dates: _____

20. In the last month, have you been treated with any Botulinums YES / NO
(eg. Botox, Xeomin, Jeuveau or Dysport)? If yes, please list: _____

21. Have you taken Accutane (or products containing isotretinoin) or Tretinoin YES / NO
(eg. Retin-A, Renova) in the last 6 months?

22. Have you had any unprotected sun exposure, used tanning creams YES / NO
(including sunless tanning lotions) or tanning beds/lamps in the last month?

For Women Only:

23. Are you pregnant or breastfeeding? YES / NO

Signature: _____ Date: _____

Reviewed by: _____Date: _____