



Patient Name: _____ **Date of Birth/Age:** _____ **Date:** _____

Please identify any current or past conditions by circling those that apply:

- | | | |
|--|------------------------|---------------------------|
| History of adverse reaction to botulinum toxin | History of Anaphylaxis | Multiple Severe Allergies |
| Facial Acne | Hives | Herpes |
| Immunosuppressive Therapy | Autoimmune Disease | Facial Rashes |
| Active Inflammatory process Infection (at proposed injection site) | | Myasthenia Gravis |
| Lambert-Eaton Syndrome | | |

Have you had prior treatment with: ___ Dermal Fillers (Versa, Juvederm, Restylane)
 ___ Neurotoxin (Xeomin, Botox, Dysport, Jeuveau)

If so, did you have any adverse reaction? ___N ___Y

Current Medications (Prescription or frequent Over-the-Counter):

Medication: _____	Dose: _____	Frequency: _____
Medication: _____	Dose: _____	Frequency: _____
Medication: _____	Dose: _____	Frequency: _____
Medication: _____	Dose: _____	Frequency: _____
Medication: _____	Dose: _____	Frequency: _____

Current Supplements:

Supplement: _____	Dose: _____	Frequency: _____
Supplement: _____	Dose: _____	Frequency: _____
Supplement: _____	Dose: _____	Frequency: _____

Known Drug Allergies: ___ No Known Drug Allergies

Medication: _____	Reaction: _____	Last Taken: _____
Medication: _____	Reaction: _____	Last Taken: _____
Medication: _____	Reaction: _____	Last Taken: _____

Signature of Patient

_____ Signature

_____ Date