Aesthetic
SOLUTIONS NY

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BRIEF MEDICAL HISTORY

Name_____ Phone_____

Age_____ Ht._____ Wt._____

MEDICATIONS:_____

ALLERGIES:_____

Are you pregnant or lactating? Yes ☐ No ☐

Physician's Name_____ Tel #_____

Last Botox Treatment Date: _____ Area: _____

Check any of the following illnesses you have or have ever had in the past (or family history):

☐ Myasthenia Gravis	☐ Hepatitis	☐ Autoimmune Disease	☐ Numbness
☐ Muscle Weakness	☐ Eye Disease	☐ Vision Problems	☐ Amyotrophic
☐ Lateral Sclerosis (ALS)	☐ Eaton Lambert Disorder		

If any of the above illnesses please explain:

_____

Are you on Aminoglycosides or any other antibacterial medication to treat bacterial infections?

Yes ☐ No ☐ If **Yes** please explain: _____

Previously hospitalized or had any surgical procedures?

Yes ☐ No ☐ If **Yes** please explain: _____

I acknowledge that i was informed on the amount of units required to be injected per area at the time of evaluation by my practitioner, and that any lesser amount to be injected was done by my request, and may not produce the full desired effect. I acknowledge that if the desired movement or muscle movement restriction is not achieved further/additional units will need to be injected. I also Acknowledge that additional PAYMENTS will be required.

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 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