STEINMANN AESTHETICS
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BOTOX® MEDICAL HISTORY

Name: _____ Date: _____
Date of Birth: _____ Age: _____ Ht: _____ Wt: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Preferred Telephone: (_____) _____ - _____

Primary Physician's Name & Number: _____
Please List All Medications you are Currently Taking: _____
_____
_____
Allergies: _____ Are you on Antibiotics at this Time? ☐ 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 ☐ Numbness ☐ Muscle "Weakness" ☐ Multiple Sclerosis
☐ Amyotrophic Lateral Sclerosis ☐ Neurological Disorders ☐ (ALS) Parkinson's Disease
☐ Lambert-Eaton Syndrome ☐ Allergies to Human Albumin or Bovine (Cow's Milk)

Please list and/or Explain Other Medical Conditions not-listed above: _____
_____
Previous Hospitalizations/Operations: _____
WOMEN: Are you Pregnant, Trying to get Pregnant, Or Lactating (Nursing)? ☐Yes ☐No

Have you had Plastic Surgery? ☐Yes ☐No Describe: _____
Other Surgery to your Face/Neck Areas? ☐Yes ☐No Describe: _____
Have you had Botox Injections Before? ☐Yes ☐No
Last Treatment? _____ What Areas? _____
Happy with your Previous Botox® Treatments? ☐Yes ☐No Describe: _____
Ever had Eyelid/Eyebrow Drooping after Botox®? ☐Yes ☐No Describe: _____
Have you ever been called Sleep Eyes/Bedroom Eyes? ☐Yes ☐No Describe: _____
Do you show a lot of Upper Eye Lid when eyes are open? ☐Yes ☐No Describe: _____
Do your eyelids feel extra heavy when you don't get enough sleep? ☐Yes ☐No
Do your eyelids droop without sleep? ☐Yes ☐No Describe: _____

"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 Steinmann Aesthetics 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:** _____