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 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