Patient Neuromodulator Intake Form

General Patient Information:

First and Last Name: _____ Birth Date: _____ Age: _____

Address: _____ City: _____ Province: _____

Phone: _____ Email: _____

Occupation: _____ Sex: ☐ Male or ☐ Female

For Women: Are you currently pregnant, breastfeeding or trying to conceive? ☐ Yes or ☐ No
(You cannot receive neuromodulator or filler treatments if you are pregnant, breastfeeding or trying to conceive)

Medical History:

Medications you are currently taking or recently stopped taking: _____

_____

Please indicate allergies: ☐ Milk ☐ Wasp/Bee Other: _____

Medical Conditions and/or Recent Illnesses: _____

_____

Previous injuries or hospitalizations: _____

Family History (cancer, cardiovascular problems, diabetes, psychological problems, etc.): _____

_____

Health Conditions: (do you have a history of the following? Please select all that apply)

☐ Cold Sore (herpes)	☐ Eczema	☐ Lupus	☐ Rheumatoid Arthritis
☐ Melasma	☐ Keloid (thick) scarring	☐ Hemophilia	☐ Muscular Dystrophy
☐ Acne	☐ Hyper/hypo pigmentation	☐ Polymyositis	☐ ALS or Multiple Sclerosis
☐ Psoriasis	☐ Thyroid Imbalance	☐ Skin Cancer	☐ Guillain-Barre Syndrome

☐ Other auto-immune or neurological disease: _____

Areas to address or discuss treatment options:

☐ Fine/Deep Lines	☐ Tired Looking	☐ Teeth Grinding (Bruxism)
☐ Dynamic Wrinkles	☐ Chronic Migraines	☐ Excessive Sweating (Hyperhidrosis)

Have you previously had?

☐ BOTOX® / Dysport® / Xeomin®	☐ Facial Trauma	☐ Facial Surgery
☐ Dermal Fillers	☐ Facial Lasers	☐ Permanent fillers or implants

When was the last time you had neuromodulator (i.e. BOTOX®) treatment? _____

Have you ever had a bad reaction to neuromodulators (i.e. BOTOX® / Dysport® / Xeomin®)? ☐ Yes or ☐ No

_____	_____ (m/d/y)	_____
Patient Signature	Date	Physician / Nurse Signature