revive
MEDICAL AESTHETICS

1146 Commerce Ave. | Longview, WA 98632
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Botox & Dysport Medical History Form

Your Name: Date of Birth:

Address:

Phone: Email:

Primary Physician: Phone:

Current Medications:

List Known Allergies:

Currently Taking Antibiotics?: ☐ Yes ☐ No

Please check any of the following medications if you are taking them:

☐ Aspirin ☐ Advil ☐ Blood Thinners ☐ Vitamin E

Please check any of the following illnesses you currently have or have expierneced in the past:

☐ Myesthenia Gravis ☐ Hepatitis ☐ Eye Disease ☐ Autoimmune Disease

☐ Vision Problems ☐ Muscle Weakness ☐ Multiple Sclerosis ☐ Neurological Disorders

☐ Parkinsons ☐ (ALS) Amyotrophic Lateral Sclerosis ☐ Lambert-Eaton Syndrome

Women - are you pregnant, trying to get pregnant, lactating (nursing)? ☐ Yes ☐ No

Have you had plastic surgery or other surgery to your face/neck areas? ☐ Yes ☐ No

Have you had Botox before? ☐ Yes ☐ No If yes, date of last treatment:

Happy with prior Botox results? ☐ Yes ☐ No If no, please explain:

Areas of special concern? :

List any other medical conditions or hospitalizations/operations:

By completing and signing this form, I understand the questions asked of me and the information I have provided to be true, current and accurate. Should my medical health change, I will notify the office immediately. I do not hold any staff member responsible or liable for any errors resulting from omissions in this form. I understand the information obtained is essential to determine my medical and cosmetic needs and provisions of treatment. Furthermore, by signing this form I give my consent for photographs to be taken to accurately document my treatment. I give my permission for my photos to be used for advertising as needed by Revive Medical Aesthetics.

Patient Signature Date Signed