BEAUTOX BAR

Patient Health History and Intake Form **Date _____**

Name _____ Male/ Female _____

Address _____City _____ State _____ Zip _____

Home Phone _____ Cell _____Email_____

Birthdate _____, Emergency Contact _____ Phone _____

Please check any and all the medications you are currently taking and/or have taken in the last two weeks from the below list:

__ Aspirin	__ Advil	__ Motrin	__ Ibuprofen
__ Aleve	__ Naprosyn	__ Excedrin	__ Coumadin
__ Warfarin	__ Plavix	__ Lovenox	__ Arnica

Please check any and all supplements and topical serums, oils, or creams in the last two weeks:

__ Vitamin E	__ Vitamin A	__ RetinA	__Renova
__ Tretinoin	__ Differin	__ Triluma	__ Gingko Biloba
__ Omega-3 fatty acids	__ Cod liver oil	__ CoQ10	__ Garlic/ Ginger

List all medications and allergies to foods such as eggs, egg products, and Albumin:

Please answer the below questions:

Are you pregnant? Y/N

Do you have Chronic Sinusitis? Y/N

Have you ever had Botox®? Y/N Last treatment date _____

Have you ever had filler treatment? Y/N Last treatment date _____

Have you ever had a negative response to injection treatments? Y/N

Do you have a special event in the next week? Y/N

Have you been diagnosed with a neurological disease or autoimmune disease? Y/N

If yes, what specifically was diagnosed and when? _____

How is your pain tolerance to injections? 1 2 3 4 5 1 being low, 5 being high

I give permission for Beautox Bar LLC to email me a monthly newsletter and occasional specials.

Signature _____, Date _____

I certify that the above information is correct to the best of my knowledge.

Signature _____, Date _____