Patient Health History Intake Form **Date ____________**

Name ____ Male/ Female ______

Address ____

City __________________________________, State _________ Zip ____________

Cell ________________Email_________________________

Birthdate __________, Emergency Contact _______________________ Phone _____________
Emergency Contact Relationship _________________

How did you hear about us? Google Facebook Instagram Family Member Friend Staff person at Beautox Bar __________ LinkedIN Advertisement Other ___________

Demographics: Married Divorced Single Separated Widowed
Occupation: _________________________________

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	__ Accutane

____ Others

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

____ Others

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

Please answer the below questions:
Alcohol Use? Daily Weekly Social Rarely Never
Are you pregnant? Y/N
Are you breast feeding? 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
If yes, what happened?
Do you have a special event in the next week? Y/N
How is your pain tolerance to injections? 1 2 3 4 5 1 being low, 5 being high
Do you have a defibrillator? Y/ N
Do you have a pacemaker? Y/ N

Inoculations:
Have you been vaccinated within the last 30 days? Y/N
If yes, what was the date of your last injection?
Which vaccine did you have?
Did you have more than one injection? Y/N If yes, what are the dates of both injections?
What brand of vaccine did you receive?
Any negative reactions to the vaccine? Y/N
High temperature? Y/N
Loss of taste/ smell? Y/N
Flu feeling? Y/N
Tested positive for Covid after injection(s)? Y/N
Blood clotting? Y/N
Stroke? Y/N
Heart issues? Y/N
Hyper Inflammation Reaction to current fillers? Y/N

Your Medical History and Your Family History:

List the medical conditions you have had as well as your family members who has had or does have the medical condition(s) below:
Mother, Father, Son, Daughter, Brother, Sister, Maternal Grandparent, Paternal Grandparent
(Do **not** include Aunts, Uncles, Cousins, or any distant relatives)

Medical Condition	Your History	Family History	Who in family?
Allergies	Y/N	Y/N	_______________
Arthritis	Y/N	Y/N	_______________
Asthma	Y/N	Y/N	_______________
Autoimmune Disease	Y/N	Y/N	_______________
Bleeding Disorders	Y/N	Y/N	_______________
Blood Clots	Y/N	Y/N	_______________
Cancer	Y/N	Y/N	_______________
Chronic Sinusitis	Y/N	Y/N	_______________
Diabetes	Y/N	Y/N	_______________
Heart Disease	Y/N	Y/N	_______________
Herpes/ Cold Sores	Y/N	Y/N	_______________
High Blood Pressure	Y/N	Y/N	_______________
HIV/ AIDS	Y/N	Y/N	_______________

Melanoma	Y/N	Y/N	_______________
Migraine Headaches	Y/N	Y/N	_______________
Neurological Disease	Y/N	Y/N	_______________
Repeated Infections	Y/N	Y/N	_______________
Seizures	Y/N	Y/N	_______________
Skin Cancer	Y/N	Y/N	_______________
Thyroid trouble	Y/N	Y/N	_______________
Tuberculosis	Y/N	Y/N	_______________

Personal Medical Condition:
Height ______ Weight_______

Hospitalization History
Last Time in Hospital Date________
Name of Hospital _____________________________
What was the reason for your hospitalization?

Surgery History
Last time you had surgery ___________
What was the surgery for?
Where was the surgery?
Have you had plastic surgery before? Y/N
If so, when?
What did you have done?

I certify that the above information is correct to the best of my knowledge. This information is only for clinic use and will not be shared with others.

Signature ____, Date ___________________________

Beautox Bar LLC *Nicole Langer and Elizabeth Peterson* , Owners