The Botox Spot.

Health History Form

Last Name, First Name | Date of Birth | Today's Date

Email Address | Phone #

Home Address | City | State | Zip

Emergency Contact | Relationship | Phone Number

How Did You Hear About Us?

Please List All Medical Conditions

Please List All Medications

Please List All Surgeries

Please List All Allergies

Do You Have Any of the Following?

Pregnant ☐
Breast Feeding ☐
Neurological Disorders ☐
Bleeding Disorders ☐
Head or Neck Injuries ☐
Facial Injuries ☐
Infection ☐
History of Cold Sores ☐
Fever, Chills or Sweats ☐
Thyroid Problems ☐
Thickened Scars ☐
Lupus ☐
Excessive Sweating ☐
Implants ☐
Anxiety ☐