



Full Name _____ DOB ____ / ____ / ____ Contact Phone _____

1. Are you interested in obtain Botox Injections in our office?

- Yes No

If yes, proceed to the following questions:

2. Please indicate which of the following areas you are interested in receiving botox injections for

- Forehead lines Crow's feet lines around the eyes
 Vertical 11 frown lines between the eyebrows

3. Have you ever received Botox injections before?

- Yes No

4. Do you have any known allergies or sensitivities to botulinum toxin or any components of Botox injections?

- Yes No

5. Have you experienced any adverse reactions to previous cosmetic treatments or injections?

- Yes No

6. Do you have any medical conditions? (please select all that apply)

- Muscle or nerve disorders Bleeding disorders Skin cancer
 Skin infections or conditions at the treatment sites Keloids
 Allergic reactions to injectables or anesthetics
 Chronic diseases (diabetes, hypertension) Other _____

7. Are you currently pregnant or trying to get pregnant?

- Yes No

8. Are you currently taking any medications

- Yes No

Thank you for completing the questionnaire. Please return this form to the front desk or hand it to your healthcare provider during your appointment.