PENSACOLA WELLNESS SOLUTIONS
Cosmetic Treatment History

Name_____ **DOB:** _____

Address _____

City_____**State**_____**Zip**_____

Email _____

Home Phone_____ **Work/Cell Phone**_____

Primary Physician's Name_____ **Phone** _____

Please list all medications you are currently taking: _____

_____

Please List Allergies: _____ **Are you on Antibiotics at this time?**_____

Circle any of the following illnesses you have or have ever had in the past:

Myesthenia Gravis Hepatitis Eye Disease Autoimmune Disease Vision Problems Numbness Muscle Weakness Multiple Sclerosis Amyotrophic Lateral Sclerosis (ALS) Parkinson's Disease Neurological Disorders Lambert-Eaton Syndrome

List and explain any other conditions not listed above: _____

_____

PreviousHospitalizations/Operations:_____
_____

WOMEN: Are you Pregnant, Trying to get Pregnant, or Lactating (nursing)? _____

Have you had Plastic Surgery or other surgery to your face/neck areas when?_____

_____

Name: _____ **DOB:** _____

Please check the appropriate box below that applies to your visit today:

Initial Consult ____ Follow Up Consult ____ Botox ___ Juvederm ____ PRP ____ Other ____

If treated before, when was your last treatment: _____

Were you pleased with your results? Yes____ No _____

If no, please explain: _____

_____

Have you ever had eyelid/eyebrow droop after Botox? Yes _____ No ____ N/A _____

Do you show a lot of upper eye lid when eyes are open? Yes _____ No ____

Do your eyelids feel extra heavy when you don't get enough sleep? Yes ____ No _____

Do your eyelids droop without sleep? Yes _____ No _____

Do you have areas of special concern? _____

I understand the information on this form is essential to determine my medical and cosmetic needs and the provision of treatment. I understand that if any changes occur in my medical history/health I will report it to the office as soon as possible. I have read and understand the above medical history questionnaire. I acknowledge that all answers have been recorded truthfully and will not hold any staff member responsible for any errors or omissions that I have made in the completion of this form.

Print Name: _____

Patient Signature_____**Date**_____

For Medical Personnel Only:

Height _____ *Weight* _____ *BP* _____ *Pulse* _____