# Botox / Neuromodulator Consultation & Pre-Treatment Intake

*T&R Clinic, P.A. · Anum Ali, FNP-C*

*Printable copy - complete by hand and bring it to your appointment, or fill this form out online.*

## PATIENT INFORMATION

**Full legal name:** _____

**Date of birth:** _____

**Age:** _____

**Sex:** _____

**Home address:** _____

**City:** _____

**State:** _____

**ZIP code:** _____

**Primary phone number:** _____

**Secondary phone number:** _____

**Email address:** _____

**Emergency contact name:** _____

**Emergency contact relationship:** _____

**Emergency contact phone number:** _____

**Primary care provider:** _____

**Primary care provider address:** _____

**Primary care provider phone number:** _____

## REASON FOR VISIT

**What concerns would you like to address today? (check all that apply):**

- ☐ Glabella (11's / frown line)
- ☐ Forehead lines (Frontalis)
- ☐ Crow's feet
- ☐ Brow lift
- ☐ Chin dimpling
- ☐ Bunny lines
- ☐ DAO muscle (downward pull from corners of mouth)
- ☐ Neck bands
- ☐ Lip flip / gummy smile
- ☐ Other

**Other concern:** _____

**What results are you hoping to achieve?:**

_____

**Have you previously received Botox, Dysport, Xeomin, Jeuveau, or another neuromodulator? (choose one):**

- ☐ Yes
- ☐ No

**Date of last treatment:** _____

**Product used:** _____

**Approximate units received:** _____

**Did you experience any complications or side effects? (choose one):**

- ☐ Yes
- ☐ No

**Please explain:**

## MEDICAL HISTORY

*Optional - fill in whatever applies to you.*

**Please check any medical conditions you currently have or have had in the past:**

- ☐ Neuromuscular disorder
- ☐ Myasthenia gravis
- ☐ ALS / Lou Gehrig's disease
- ☐ Multiple sclerosis
- ☐ Bell's palsy
- ☐ Facial nerve disorder
- ☐ Difficulty swallowing
- ☐ Muscle weakness
- ☐ Seizure disorder
- ☐ Bleeding disorder
- ☐ Blood clotting disorder
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Diabetes
- ☐ Thyroid disorder
- ☐ Autoimmune disease
- ☐ Pregnancy
- ☐ Breastfeeding
- ☐ Anxiety disorder
- ☐ Depression
- ☐ Chronic migraines
- ☐ Other
- ☐ None of the above

**Other condition:** _____

## ALLERGIES

**Do you have any allergies? (choose one):**

- ☐ Yes
- ☐ No

**Please list all allergies and reactions (medications, latex, foods, topical products, adhesives, etc.):**

## VACCINATIONS

**Have you received any vaccinations in the last two weeks (14 days)? (choose one):**

- ☐ Yes
- ☐ No

**Please list the vaccinations and the dates you received them:**

## HERPES SIMPLEX VIRUS (HSV) HISTORY

*HSV is a common viral infection that may cause cold sores or fever blisters. Treatment around the face may occasionally trigger an outbreak in individuals with a history of HSV.*

**Have you ever had (check all that apply):**

- ☐ Cold sores
- ☐ Fever blisters
- ☐ Oral herpes (HSV-1)
- ☐ Genital herpes (HSV-2)
- ☐ No known history of HSV

**Date of most recent outbreak:**

**Frequency of outbreaks:**

**Are you currently taking antiviral medication? (choose one):**

- ☐ Yes
- ☐ No

**Antiviral medication name and dosage:**

## MEDICATIONS & SUPPLEMENTS

**List ALL prescription medications, over-the-counter medications, vitamins, herbal supplements, injections, hormones, and topical products you currently use (name, dosage, reason for use). Write "None" if you take none.:**

**Are you currently taking any of the following?:**

- ☐ Aspirin
- ☐ Ibuprofen / NSAIDs

- [ ] Blood thinners
- [ ] Fish oil / Omega-3 supplements
- [ ] Vitamin E supplements
- [ ] Steroids
- [ ] Muscle relaxers
- [ ] Antibiotics
- [ ] Sleep medications
- [ ] Anxiety medications
- [ ] None of the above

## SKIN & AESTHETIC HISTORY

*Optional - fill in whatever applies to you.*

**Please check any procedures or treatments you have had:**

- [ ] Botox / Dysport / Xeomin
- [ ] Dermal fillers
- [ ] Facial surgery
- [ ] Eyelid surgery
- [ ] Laser treatments
- [ ] Microneedling
- [ ] Chemical peels
- [ ] Plastic surgery
- [ ] Other
- [ ] None of the above

**Approximate dates / details of the procedures checked above:**

**Have you ever experienced any of the following?:**

- [ ] Drooping eyelids after injections
- [ ] Uneven facial appearance after injections
- [ ] Allergic reaction to injectable products
- [ ] Excessive bruising
- [ ] Difficulty swallowing after injections
- [ ] None of the above

**Have you ever experienced complications from a cosmetic procedure? (choose one):**

- [ ] Yes
- [ ] No

**Please explain:**

**Do you smoke or use nicotine products? (choose one):**

- [ ] Yes
- [ ] No

**Do you consume alcohol regularly? (choose one):**

- [ ] Yes

☐ No

**Drinks consumed per week:** _____

**Do you have any upcoming important events within the next 2 weeks? (choose one):**

☐ Yes
☐ No

**Please explain:**

_____

_____

_____

## PATIENT ACKNOWLEDGMENT

I certify that the information provided above is complete and accurate to the best of my knowledge. I understand that withholding medical information may increase the risk of complications or adverse reactions.

I understand that the provider may determine I am not an appropriate candidate for Botox or neuromodulator treatment based on my medical history, medications, anatomy, or other factors.

**Acknowledgment:**

☐ I certify the above information is complete and accurate to the best of my knowledge.

**Patient signature**

_____

**Date:** _____