GBMC

Injectable Medical Information Form

Have you ever had botulinum toxin product (BOTOX®, Dysport®, DAXXIFY®, MYOBLOC®, Xeomin®, or other)? _____
If **YES**, when was your last treatment date? _____
Any complications? _____

Have you ever had dermal fillers (JUVÉDERM®, Restylane®, RHA®, or other)? _____
Have you ever had any facial implants, lifts, or other facial procedures? _____
_____
If **YES**, when was your last treatment and/or surgery?
_____
What area? _____
Any complications? _____

Please mark YES or NO for history of any of the following:	**YES**	**NO**
Pregnancy or breast feeding		
History or presence of severe allergies		
Allergy to lidocaine		
Allergy to human albumin		
Allergy to cow's milk protein		
Allergy to gram-positive bacteria		
Bleeding disorder		
History of or current use of anticoagulants/blood thinners		
Neurological disease		
Swallowing or breathing problems		
Vision problems		
Numbness of muscle weakness of the face		
History of peri-oral herpes		
Bell's palsy		
Trigeminal neuralgia		
Use of immunosuppressants		
Autoimmune disease		
Recent dental work or cleaning		
Recent viral or bacterial illness or infection		
Recent vaccinations or medical procedures		
Keloid scarring		
Active inflammatory skin conditions (acne, rosacea, dermatitis, or other)		

Please provide details if you marked YES for any of the above: _____
_____

Please list any other medical conditions not listed above: _____