Premier Plastic  *Surgery Center*

Botox / Dysport Questionnaire

Name_____ Date_____/_____/20___

1. Have you ever had Botox before? _____If no, skip to question 3.

If yes, which areas were treated and when? _____

2. Did you have any type of problems after your Botox injection? _____

If yes, explain._____

3. Which areas are you interested in having treated now? _____

4. Have you ever been told you have any of the following diseases? (circle any that apply)

Myesthenia Gravis

Amyotrophic Lateral Sclerosis

Eaton-Lambert Syndrome

Any other neuromuscular disease

5. Are you pregnant, planning to get pregnant soon, or nursing? _____

6. Do you take aspirin, Coumadin, or any other anticoagulants (blood thinners)?___

7. Are you taking any antibiotics?_____ If so, which one?_____

8. Are you taking any blood pressure medications? _____

9. Do you now have or have you recently had any infection (such as acne) in the area(s) designated for Botox injection(s)? _____

10. What are your expectations from Botox treatment(s)?

_____

11. Do you have any specific questions about Botox we can answer for you?

_____

_____

Signed_____ Date_____/_____/_____

Reviewed by_____ Date_____/_____/_____