COSMETIC

MEDICAL HISTORY

Are you taking any of the following medications: Aspirin Coumadin Warfarin Plavix

Please list ALL other medications, including Motrin/Advil, herbs and vitamins which you are taking:

Are you on antibiotics at this time? _____NO _____YES

What medications are you ALLERGIC to? No known allergies Penicillin Sulfa Codeine

Others_____

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

No health problems	Hepatitis	Other:
Myastenia Gravis	Muscle Weakness	_____
Eye Disease or Vision Problems	Numbness	_____
Autoimmune Disease	Multiple Sclerosis	_____
Parkinson's Disease	Neurological Disorders	_____
ALS	Ptosis (droopy eyelids)	

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 that I will report it to the office as soon as possible. I have read and understand the above medical history questions.

Patient Signature_____ **Date**_____