Body Garage
6301 S. Minnesota Avenue Suite 300
Sioux Falls, SD 57108
605-334-2443

Medical History

Date: _____
Last Name: _____ First Name: _____ MI: _____
Address: _____Suite/Apt. No: _____
City: _____ State: _____ Zip: _____
Cell Phone: _____ Home Phone: _____ Work Phone: _____
E-Mail: _____
Occupation: _____ Best way to contact you: _____
Date of Birth: _____ Sex: Male Female
Family Doctor: _____Dr. Phone No.: _____
Pharmacy: _____ Pharmacy Phone No.:_____

How did you hear about us? _____

If you were referred by one of our patients, please share their name so we may thank them: _____

Past Medical History (Please circle all that apply)

Acne	Coronary Artery Disease	Hyperthyroidism
Anxiety	Depression	Hypothyroidism
Arthritis	Diabetes	Leukemia
Asthma	End Stage Renal Disease	Lung Cancer
Atrial Fibrillation (Irregular Heartbeat)	GERD (Reflux)	Lymphoma
Blood Clots	Hearing Loss	Prostate Cancer
Bone Marrow Transplant	Hepatitis	Radiation Treatment
Breast Cancer	Hypertension	Seizures
Colon Cancer	HIV/AIDS	Stroke
COPD	Hypercholesterolemia	Thyroid Disease

None of the above

Have you ever had cancer? YES NO If yes, please explain: _____

Have you ever had surgery? YES NO

If so, when and what area?_____
_____

Do you have ANY current or chronic medical illness, specifically: Myasthenia Gravis, Amyotrophic Lateral Sclerosis, or any other neuromuscular disorders? YES NO Please list: _____

Are you currently under a Doctor's care? YES NO If so, for what reason? _____
_____

Medications

(Please enter all current medications without the dosage) _____
_____
_____

Allergies

Are you allergic to Latex? YES NO Are you allergic to Lidocaine (a local anesthetic)? YES NO

Are you allergic to any medications or have any other allergies? YES NO If yes, please list: _____
_____
_____

Please answer all of the following questions

Have you had cold sore breakouts (oral herpes) in the past year? YES NO

Are you on Corticosteroids or Immunosuppressive therapy? YES NO

Have you taken anticoagulants in the last year? YES NO

Have you previously received BOTOX injections before? YES NO

When: _____ Area Treated: _____ Dosage Amount: _____

For women:
-Are you or could you be pregnant? YES NO
-Are you breast feeding? YES NO
-Are your menstrual periods regular? YES NO

I HAVE READ AND UNDERSTAND THE ABOVE QUESTIONS. BY SIGNING THIS DOCUMENT I AGREE THAT THE INFORMATION CONTAINED HEREIN IS TRUE TO THE BEST OF MY KNOWLEDGE.

SIGNATURE: _____ DATE: _____

FOR STAFF USE ONLY:

Reviewed by: _____ DATE: _____