Client Medical History

Name:_____Date:_____

Medical Exclusions:

1. Are you pregnant and/or breastfeeding?
   Yes No
2. Do you have a neurological condition (such as Myasthenia Gravis, Lambert-Eaton Syndrome, ALS, motor neuropathy, etc.)?
   Yes No
3. Do you have a bleeding disorder?
   Yes No
4. Are you taking any blood-thinning medications (such as aspirin, Coumadin, Plavix, Persantine, etc.)?
   Yes No
5. Do you have any active facial skin infections (such as fever blisters or cold sores)?
   Yes No

Past Medical History:

Current Medications:

Medication Allergies:

Client Signature:_____Date:_____

Injector Signature:_____Date:_____

Physician Signature:_____Date:_____