Your Clinic Name

Good Faith Exam — Neurotoxin Injections

Botox®, Dysport®, Xeomin®, Jeuveau®, Daxxify®, Letybo®
Patient questionnaire to complete before your clinic's Good Faith Exam.

Part A — Patient completes

Patient information

Full name _____ Preferred name (optional) _____

Date of birth _____ Phone _____ Email _____

Address

_____

_____

Treatment areas

Which areas are you interested in?

☐ Forehead lines ☐ Frown lines between the eyebrows ☐ Crow's feet ☐ Other:

Other area details _____
Your provider will decide what is appropriate.

Health history

Check any you have now or have had before.

☐ None of these
☐ Heart disease, heart failure or irregular heartbeat
☐ Diabetes
☐ Kidney disease
☐ Autoimmune disease (for example lupus, rheumatoid arthritis, multiple sclerosis)
☐ Seizures or epilepsy
☐ HIV or another condition that weakens the immune system
☐ High or low blood pressure
☐ Stroke, mini-stroke or blood clots
☐ Thyroid disease
☐ Liver disease or hepatitis
☐ Muscle or nerve condition (for example myasthenia gravis, Lambert-Eaton syndrome, ALS)
☐ Bleeding or clotting disorder
☐ An infection or illness right now

☐ Cancer (current or past). If yes, type and any treatment in the past 12 months: _____

☐ Other condition: _____

Part A — Patient completes (continued)

Medicines and supplements

List all medicines, vitamins and supplements you take

_____

_____

_____

_____

	Yes	No
Do you take a blood thinner (for example warfarin, Eliquis, Xarelto, Plavix)?	☐	☐
In the past 7 days, have you taken aspirin, ibuprofen, naproxen, fish oil, vitamin E or ginkgo?	☐	☐

Allergies

☐ No known allergies ☐ Latex ☐ Tape or adhesive

Medicine allergies and what happened

_____

_____

Other (food, preservatives and so on): _____

Have you ever had a severe allergic reaction (trouble breathing, throat swelling) or been told to carry an EpiPen?	☐	☐

Pregnancy

Are you pregnant, trying to become pregnant, or breastfeeding?	☐	☐	☐ Does not apply

Questions about neurotoxin treatment

	Yes	No
Have you ever had an allergic or bad reaction to Botox, Dysport, Xeomin, Jeuveau, Daxxify or Letybo?	☐	☐
Are you allergic to cow's milk protein?	☐	☐
Do you have, or have you had, trouble swallowing, speaking or breathing?	☐	☐
Have you had a drooping eyelid or eyebrow, Bell's palsy or weakness in your face?	☐	☐
Do you have a rash, cold sore, breakout, infection or open wound where you want treatment?	☐	☐
Have you had Botox or a similar treatment in the past 6 months?	☐	☐

If yes, product _____ Area _____ Date _____

Are you taking, or have you recently been given, an antibiotic such as gentamicin, tobramycin or amikacin (usually given by IV or injection)?	☐	☐
In the past 6 months, have you had fillers, surgery, laser or other procedures on your face, or do you have any planned?	☐	☐

If yes, describe _____

Patient statement and signature

I have answered these questions completely and truthfully to the best of my knowledge. I understand the prescriber will use my answers to decide whether this treatment is right for me, and that this exam does not guarantee I will be treated. I will tell the clinic before treatment if my health, medicines, allergies or pregnancy status change.

Patient signature _____ Printed name _____ Date _____

If signed by a legal representative: name and relationship _____