

Basic Information

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____

Employer: _____ WorkPhone: _____

Email Address: _____ Preferred Pharmacy: _____

Emergency Contact: _____ Phone Number: _____

How did you learn about Elan? _____

Medical History

Primary Family MD: _____

Other Specialist MDs: _____

Current Diagnoses: _____

(Circle Yes, if applicable)

High Blood Pressure Yes/No

Cardiovascular disease (heart attack, stroke, bypass surgery, angioplasty, stents) Yes/No

Neurologic abnormalities (ALS, Lou Gehrig's disease, myasthenia gravis, Lambert-Eaton, multiple
sclerosis, Bell's palsy) Yes/No

Bleeding or clotting disorder Yes/No

Diabetes Yes/No

Migraine headaches Yes/No

Eyelid lag or ptosis Yes/No

Glaucoma or other eye problems Yes/No

Hepatitis or HIV Yes/No

Fever blisters Yes/No

Keloids Yes/No

Surgeries (list ALL): _____

Allergies (list ALL): _____

Have you ever had Anaphylactic reaction to anything in the past? YES/ NO (Explain) _____

Daily Medications (list ALL): _____