Medical History and Consent Form

CONFIDENTIAL

Name: ………………………………………………………………………..

DISCLAIMER: We do not facilitate reviews of botulinum toxin or dermal fillers. However, we are always accessible for any complications that may arise from treatments. Refunds are not offered once treatment is administered or no show and cancellations.
I have signed below to confirm I have read and understood the above.

Signed: ……………………………………………………… Date: ………………………

All data collected is in accordance with the General Data Protection Regulation 2018
Please ask to see our privacy policy or read it on our website.

Personal Information

Patient Personal Information

Title ______ First Name ______ Middle Name(s) ______

Surname ______

Address ______

______

Postcode ______ Telephone Number ______

Date of Birth ______ Age ______ Male / Female ______

Email ______

Next of Kin ______ Relationship ______

Next of Kin Telephone Number ______

Name of GP ______
(We will not routinely contact your GP or your next of kin. This is for emergency use only.)

General Lifestyle Information

Patient General Lifestyle Information

Occupation ______

Do you smoke? ______ If so, how many a day? ______

If you have stopped smoking, when did you give up? ______

Do you drink alcohol? ______ If so how many units a week*? ______

What is your height? ______ Weight ______

Do you take regular exercise? ______ Type ______

Do you follow any special diet? ______

* A medium (175ml) glass of wine is two units; a single spirit measure is one unit and a pint of beer is 2-3 units.

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Medical History

Please complete the following medical questionnaire. If you are unsure of any details, please discuss with the practitioner treating you. Male patients should start at section B.

Section A

Are you currently pregnant or breast feeding? ______ Yes ☐ No ☐

Are you trying to conceive or undergoing IVF treatment? ______ Yes ☐ No ☐

Date of last menstrual period ______

Section B

Do you suffer from or have you previously suffered from:

Pigment disorders? ______ Yes ☐ No ☐

Increased scar formation? ______ Yes ☐ No ☐

Increased light sensitivity? ______ Yes ☐ No ☐

Herpes infections (shingles, chicken pox, cold sores, genital herpes sores)? ______ Yes ☐ No ☐

Skin cancer? ______ Yes ☐ No ☐

Keloid scarring? (lumpy overgrowth of scar tissue) ______ Yes ☐ No ☐

Acne, psoriasis or any other active skin condition or infection in the area(s) you wish to have treated? ______ Yes ☐ No ☐

Amyotropic lateral sclerosis (ALS)? ______ Yes ☐ No ☐

Myasthenia gravis, Eaton-Lambert syndrome, amyotrophic lateral sclerosis, multiple sclerosis? Yes ☐ No ☐

Impaired ability to swallow or dysphagia? ______ Yes ☐ No ☐

Angina, cardiac infarction? ______ Yes ☐ No ☐

High/low blood pressure? ______ Yes ☐ No ☐

Emotional or neurological disorders, e.g. seizures (epilepsy), paralyses, depression, M.E. (Myalgic Encephalomyelitis)? ______ Yes ☐ No ☐

Migraine? ______ Yes ☐ No ☐

Bell's palsy or a stroke? ______ Yes ☐ No ☐

Glaucoma? ______ Yes ☐ No ☐

Asthma? ______ Yes ☐ No ☐

Diabetes? ______ Yes ☐ No ☐

Thyroid problems? ______ Yes ☐ No ☐

HIV, hepatitis, rheumatoid arthritis or other auto-immune diseases? ______ Yes ☐ No ☐

Nosebleeds, bruises (e. g. after a light touch) or coagulation disorders or bleeding disorders? Yes ☐ No ☐

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Section B Continued

Do you or does anyone in your family suffer from a hereditary disease? ______ Yes ☐ No ☐

Do you have any allergies or hypersensitivities?
e. g. hay fever, asthma, hypersensitivity (e.g. to collagen-containing products, lidocaine, painkillers, anaesthetics, foods, medications, plasters, latex)? ______ Yes ☐ No ☐

If so, to/what? ______

Have you ever been in hospital with a severe allergic reaction? ______ Yes ☐ No ☐

Are you currently undergoing any desensitisation treatment? ______ Yes ☐ No ☐

If you have an allergy card, please present it.

Have you recently taken any medication or are you currently taking medication? Painkillers, coagulation inhibitors, antibiotics, steroids, muscle relaxants (e.g. aspirin, warfarin, ibuprofen) or herbal preparations, vitamins and supplements. ______ Yes ☐ No ☐

Have you taken Roaccutane or Isotretinoin (for acne) in the past 12 months? ______ Yes ☐ No ☐

Have you had any recent immunisations? ______ Yes ☐ No ☐

Have you had any major surgery in the last six weeks? ______ Yes ☐ No ☐

Are you planning or currently undergoing dental treatment? ______ Yes ☐ No ☐

Have you previously undergone operations in your facial area (e.g. laser, skin peel, facelift, IPL skin resurfacing, plastic surgery, injury, etc)? ______ Yes ☐ No ☐

Do you have a phobia about blood or needles? ______ Yes ☐ No ☐

Are you prone to bruising? ______ Yes ☐ No ☐

Have you recently been on a sunbed? ______ Yes ☐ No ☐

Section C

Have you received local anaesthetic injections at your dental practice? ______ Yes ☐ No ☐

Any problems with dental local anaesthetics? ______ Yes ☐ No ☐

Have you received Botox type injections previously? If yes, how long ago? ______ Yes ☐ No ☐

Did you experience any side effects or allergy? ______ Yes ☐ No ☐

Have you received dermal filler injections? If yes, how long ago? ______ Yes ☐ No ☐

Do you know the name of the dermal filler used? If yes, please specify: ______ Yes ☐ No ☐

______

Do you have any permanent implants in your face? ______ Yes ☐ No ☐

Did you experience any side effects or allergy? ______ Yes ☐ No ☐

Which aspects of your face are you concerned about and what are your expectations about the outcome of treatment?

______

______

______

Do you have any worries or concerns about treatments or anything else that you wish to tell us? ______

______

______

______

Treatment Form

Visit No. 1

Have there been any changes to your medical history since your last consultation? Yes ☐ No ☐
If so please detail:

____

____

____

The information that I have given is to the best of my knowledge correct.
I have not knowingly withheld any medical or surgical information.
I agree to inform my practitioner of any changes to my medication or health in the future.
I have read the Consent to Treatment information fully and understand the possible complications that could occur. I have discussed these with my practitioner and agree to treatment.

I agree to the treatment described as ____________________________

____

Patient's Name ____________________________________

Signature ________________________ **Date** ______________

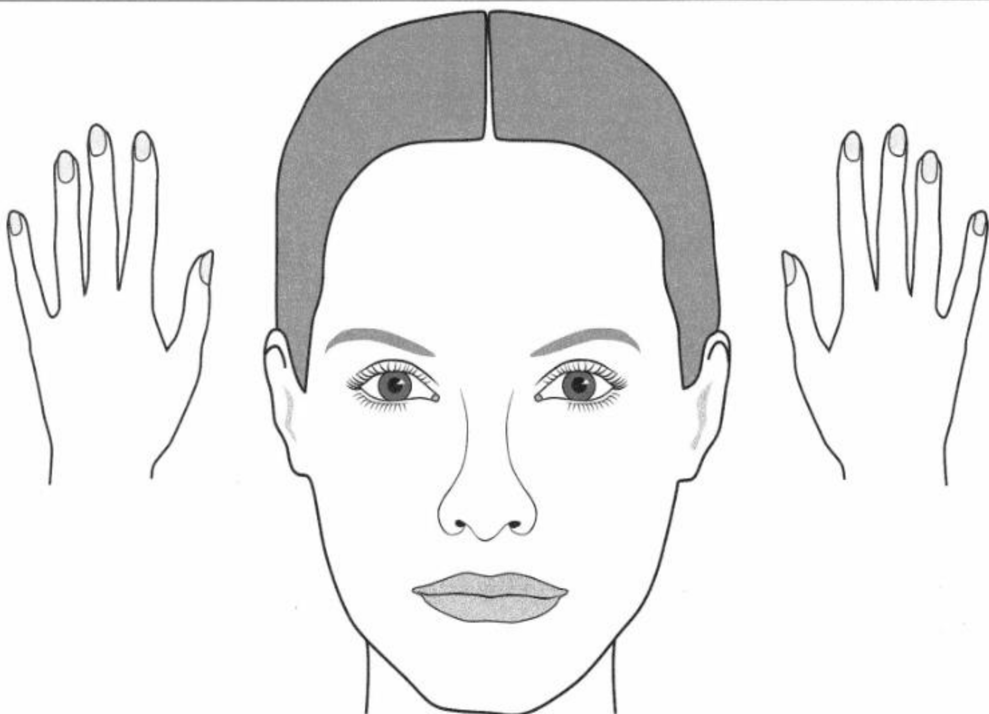
Practitioner's notes

Name (Registered Nurse/Doctor/Dentist) ________________________

Signature ________________________ **Date** ______________

Place product sticker here

Date of treatment:



Indicate areas of treatment and dosage on the diagram

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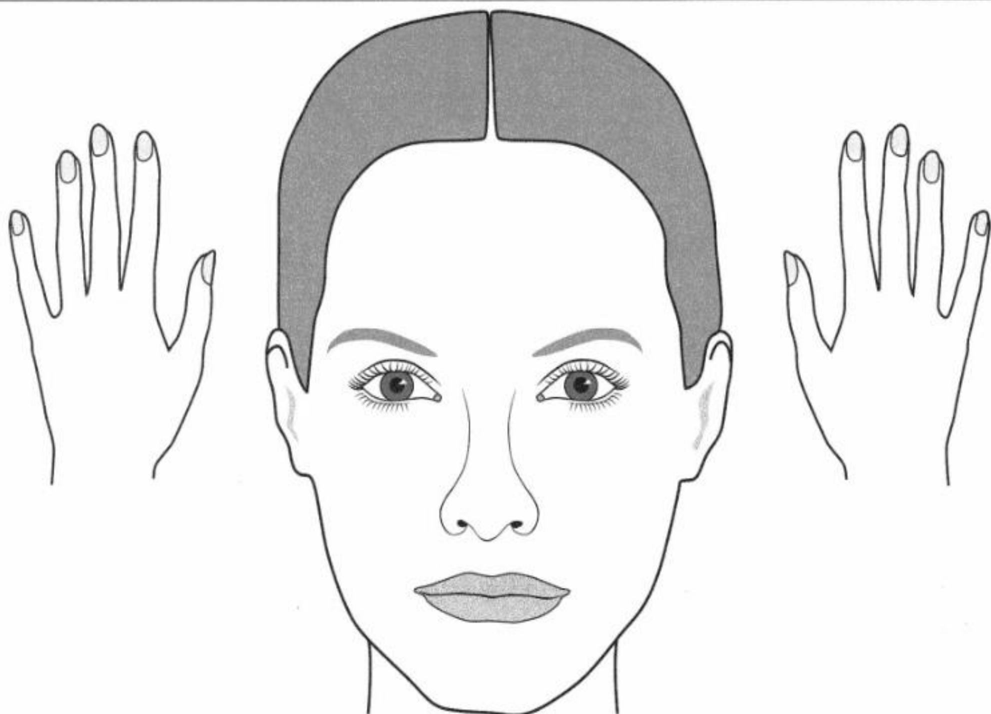

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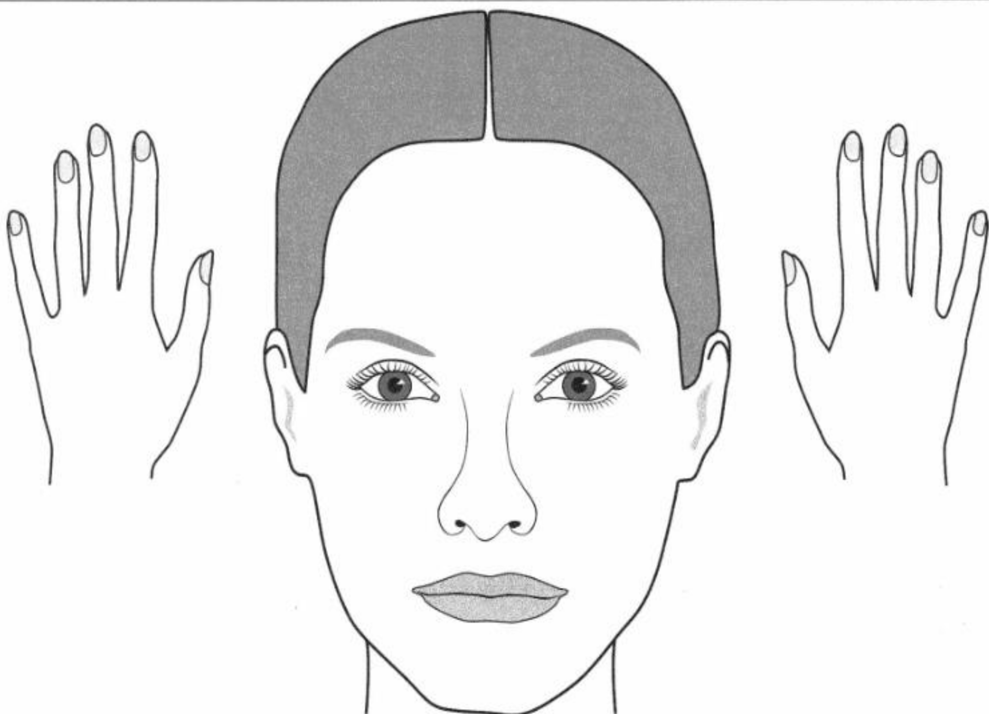

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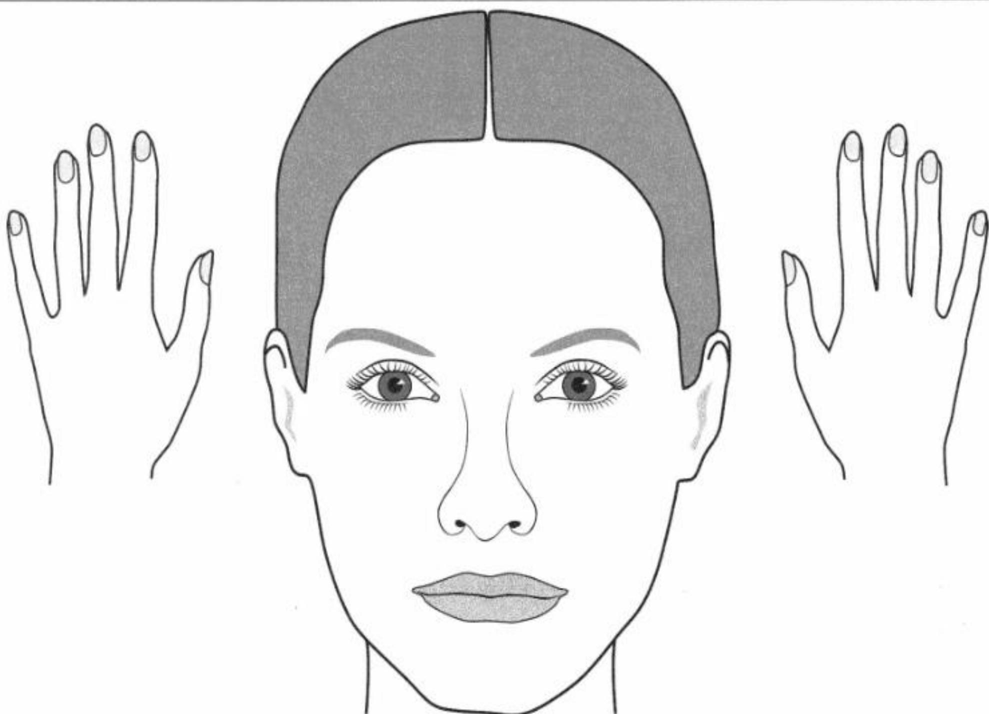

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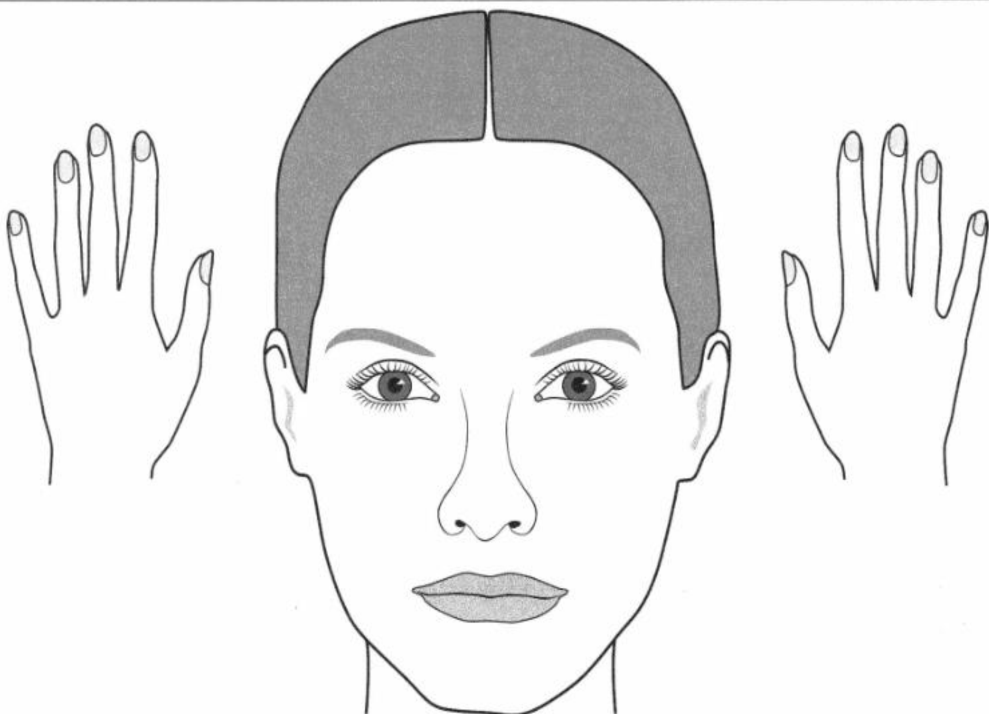

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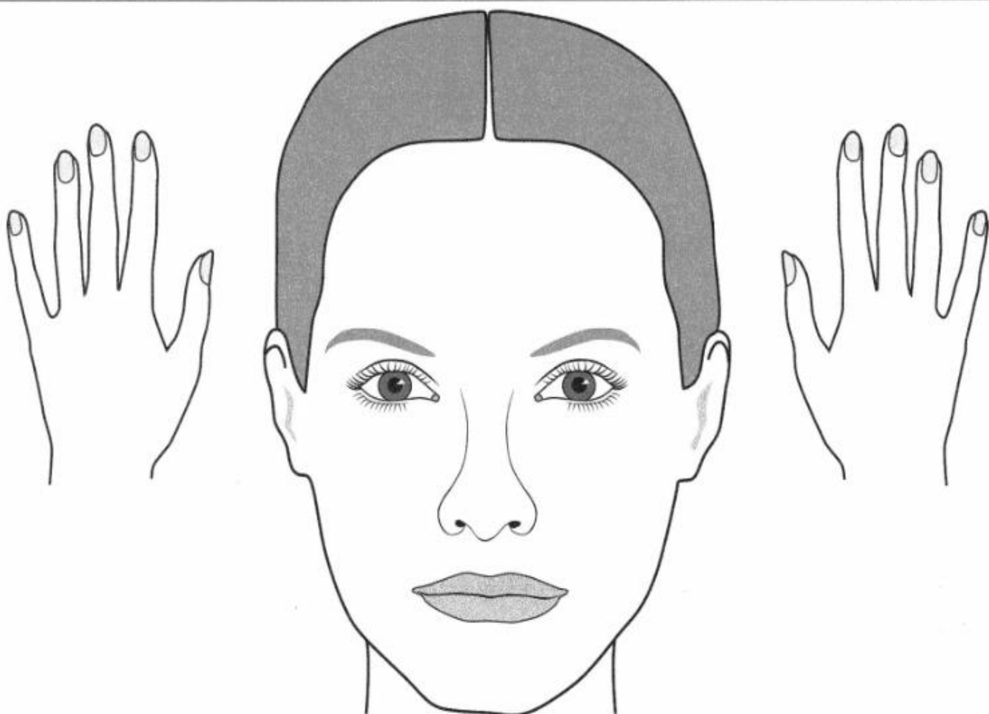

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PRACTITIONER OTHER NOTES