Full name…………………………………………………… Date of Birth ………………………………… Date ……………………….

Address ……………………………………………………………………………………………………………………………………………….

..................................................................................................................................................................

Postcode ……………………………………………… Telephone ………………………………………………………………………….

GP Name…………………………………. GP Address ……………………………………………………………………………………..

………………………………………………..GP Telephone………………………………………………………………………………….

Emergency contact………………………………………………………………Telephone…………………………………………..

**General Lifestyle information**

* Occupation ………………………………………………………………………………………………………………………………….
* Do you smoke? .................................. If so how many a day? ...........................................................
* Do you drink alcohol?........................ If so how many units a week?...............................................
* What is you height?........................... Weight………………………………………………………………………………
* Do you exercise?................................ Type………………………………………………………………………………….
* Do you follow any special diet?…………………………………………………………………………………………………..

**Patient Medical History**

**Section A**  Please circle

Are you currently pregnant or breastfeeding?.................................................................... Y N N/A

Are you trying to conceive or undergoing IVF treatment?.................................................. Y N N/A

**Section B**

* Do you suffer from or have previously suffered from:
* Pigment disorders?………………………………………………………………………………………………………… Y N
* Increased scar formation?……………………………………………………………………………………………… Y N
* Increased light sensitivity?……………………………………………………………………………………………. Y N
* Herpes infection (shingles, chicken pox, cold sores, genital herpes sores?)………………….. Y N
* Skin cancer…………………………………………………………………………………………………………………… Y N
* Keloid scarring?……………………………………………………………………………………………………………. Y N
* Acne, psoriasis or any other active skin condition or infection in the area(s)you wish to

have treated?………………………………………………………………………………………………………………… Y N

* Myasthenia Gravis, Eaton-Lambert syndrome, amyotrophic lateral sclerosis, multiple

Sclerosis?

* Impaired ability to swallow or dysphasia?......................................................................... Y N
* Angina, cardiac infarction?................................................................................................ Y N
* High/low blood pressure………………………………………………………………………………………………. Y N
* Emotional, anxiety, depression or mental health problems?............................................ Y N
* Neurological disorders, e.g. seizures (epilepsy), paralyses,

M.E (myalgic Encephalomyelitis)………………………………………………………………………………….. Y N

* Migraine?.......................................................................................................................... Y N
* Bell’s palsy or stroke?....................................................................................................... Y N
* Glaucoma?........................................................................................................................ Y N
* Asthma?............................................................................................................................ Y N
* Diabetes?.......................................................................................................................... Y N
* Thyroid problems?............................................................................................................ Y N
* HIV, hepatitis, rheumatoid arthritis or other auto immune diseases?.............................. Y N
* Nosebleeds, bruises (e.g. after a light touch) or coagulation or bleeding disorders?....... Y N
* Metal stents in the area of treatment?............................................................................. Y N
* Open wounds or legions on the face?............................................................................... Y N
* Do you or anyone in your family suffer from a hereditarory disease? Please specify……. Y N

...........................................................................................................................................

* Do you have any allergies or sensitivities?......................................................................... Y N

If so, to what?.....................................................................................................................

* Have you ever been in hospital with a severe allergic reaction?....................................... Y N
* Are you currently undergoing any desensitisation treatment?......................................... Y N
* Are you taking any medication?......................................................................................... Y N

Please specify…………………………………………………………………………………………………………………

............................................................................................................................................

............................................................................................................................................ PTO

* Have you taken Roaccutane or Isotretinoin (for Acne) in the past 12 months?................. Y N
* Have you had any recent immunisations?.......................................................................... Y N
* Have you had any major surgery in the past 6 weeks?....................................................... Y N
* Are you planning or currently undergoing dental treatment?............................................ Y N
* Have you previously underrgone operations in your facial area (e.g. laser, skin peels,

Facelift, IPL skin resurfacing, plastic surgery, injury etc?..................................................... Y N

* Do you have a phobia about blood or needles?.................................................................. Y N
* Are you prone to bruising?.................................................................................................. Y N
* Have you recently been on a sun bed?................................................................................ Y N

**Section C**

* Have you ever received local anaesthetic injections at your dental practice?.................... Y N
* Any problems with dental local anaesthetics?.................................................................... Y N
* Have you received Botulinum Toxin injections previously, such as Botox?........................ Y N
* If yes, how long ago?...........................................................................................................
* Did you experience any side effects or allergy?................................................................... Y N
* Have you received dermal fillers? If yes, how long ago?..................................................... Y N
* Do you know the name of the dermal filler used?................................................................ Y N
* Do you have any permanent implant in your body/face (e.g. chin, neck, cheek, jaw,

breast, or other area of treatment) including any pacemakers and electronic device

implants?............................................................................................................................. Y N

* Did you experience any side effects or allergy?.................................................................. Y N

Which aspects of your face are you concerned about?....................................................................................

..........................................................................................................................................................................

...........................................................................................................................................................................

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

...........................................................................................................................................................................

...........................................................................................................................................................................

The reason I have chosen this treatment is ......................................................................................................

...........................................................................................................................................................................

...........................................................................................................................................................................

My expected outcome for the treatment is………………………………………………………………………………………………….

...........................................................................................................................................................................

...........................................................................................................................................................................

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.

Patient name…………………………………… Patient Signature ………………………………………… Date………………………

Full name ……………………………..……………………… Date of Birth ………………………………… Date ……………………….