

Medical History

Please note that this is a Medical Consent Form, which will be kept confidential and will only be viewed by the Aesthetic Practitioner and the Clinical Team responsible for you whilst undergoing treatment at this cosmetic injectables clinic. Your details will be stored securely and will not be available for third parties.

If any of your answers provided raises concern, your aesthetic nurse practitioner may need to discuss matters further to ensure safe and effective treatment.

Patient Information

Name: _____

Address: _____

_____ Postcode: _____

Date of Birth: ____/____/____ Tel: _____

Email: _____

GP Name: _____

GP Address: _____

Medical History

Are you attending or receiving treatment from a doctor or specialist? Yes No

Are you taking any medication, or herbal remedies (including antibiotics, anticoagulants, muscle relaxants, St. John's Wart, roaccutane)? Yes No

Are you taking blood thinning medication (aspirin, plavix, warfarin, apixaban, rivaroxaban)? Yes No

Are you allergic to local anaesthetic injections, lignocaine, adrenaline, or EMLA/ANESTOP/LMX4 cream? Yes No

Do you have any known allergies or a history of anaphylaxis (life threatening allergic reaction)? Yes No

Additional information:

Have you suffered from or had any of the following conditions?

Heart problems including an irregular heartbeat or angina?

Yes No

High/low blood pressure or circulatory problems including Raynauds Syndrome?

Yes No

Epilepsy/blackouts?

Yes No

Bloods disorders/leukaemia/lymphoma/anaemia/cancer?

Yes No

Autoimmune disease, arthritis, or reoccurring sore throats?

Yes No

Diabetes?

Yes No

Contact dermatitis/eczema?

Yes No

Keloids (hypertrophic scarring) or recent scar tissue (6months)? This is more common in those with darker skin tones.

Yes No

Easy bruising and/or cold sores?

Yes No

Psychiatric illness/depression?

Yes No

Do you use sunbeds or sunbathe?

Yes No

Do you play a woodwind or brass instrument? (Because botulinum toxin softens wrinkles through its effects on muscles. Therefore it is best to avoid treatment if you wish to continue playing these instruments)

Yes No

Are you pregnant/planning a pregnancy/engaging in IVF treatment/breastfeeding?

Yes No

Have you had a consultation or been treated with dermal filler, botulinum toxin, laser, chemical peels or microdermabrasion before?

Yes No

Have you had an allergic reaction to any dermal filler or botulinum toxin product?

Yes No

Have you had a consultation or had plastic surgery of the face or neck, or are you planning to have surgery?

Yes No

Optional

Before and After photos are always taken to assess treatment – I understand that these are confidential. However, I give my written consent for my photos to be used to show future patients, and for marketing purposes.

I hereby give my consent to use my photos to show future clients, and for marketing purposes.

Treatments

I hereby consent to the following:

I have no known allergy to local anaesthetic cream or injections and understand that either or both may be required as part of my treatment.

I have been informed of the risks and possible side effects of treatment and accept these risks are my own. I have understood and correctly completed the medical history form.

I have been given and read the appropriate aftercare advice.

An undesired cosmetic effect, such as an unexpected appearance after treatment, can usually be avoided by clear communication between patient and healthcare provider.

I have completed the above health questionnaire to the best of my knowledge and will inform my healthcare professional if my circumstances change.

I understand that individual results achieved with facial cosmetic treatments may vary and are not guaranteed.

Please sign your name in the box below:

Date: ____/____/____

Consultation completed by: _____

Additional comments:
