Confidential Medical History Form

This questionnaire will form part of your confidential clinical records. This form will be updated at every consultation appointment.

☐ MR ☐ MRS ☐ MISS ☐ OTHER FULL NAME:

DATE of Birth: Sex: **M** ☐ **F** ☐ Address:

Postcode:

Home tel No: Work Tel No: **Mobile:**

Email: Occupation: Pregnant: **Yes** ☐ **No** ☐

Breastfeeding: **Yes** ☐ **No** ☐ Contraceptive Pill: **Yes** ☐ **No** ☐ Taking HRT: **Yes** ☐ **No** ☐ Do you smoke: **Yes** ☐ **No**

MEDICAL HISTORY:	YES	NO	DETAILS
Do you suffer from Cold Sores?			
Have you ever had hyaluronidase (Hyluron) for the removal of Dermal Fillers?			
Jaundice (hepatitis) or other liver disease?			
Rheumatic fever or Chorea (St Vitus Dance)?			
Asthma, eczema **or** other allergic disease?			
Have you ever had an anaphylaxis reaction? Do you carry an Epi Pen?			
Any heart conditions such as angina, murmur and valve problems?			
A stroke **or** blood pressure problems? A valve or joint replacement?			
An allergic reaction to substances or drugs such as; foods, latex, steroids or antibiotics?			
Have you ever had a reaction to either Botulinum Toxin or Dermal Fillers?			
Steroids within the last two years **or** any recent vaccinations?			
A valve replacement, joint replacement or implant?			
An operation or surgical treatment **or** a general anaesthetic or sedation?			
A period as an in-patient at a hospital?			
Have you any other diseases, illnesses? Or have any other medical condition?			
CURRENT MEDICAL STATUS:	**Yes**	**No**	**Details**
Do you take any pills medicines or tablets?			
Are you using an inhaler or any other form of medication?			
Are you using any complimentary supplements ie St John Wort?			
Do you suffer from fainting attacks?			
Do you bleed or bruise easily?			
Do you or any family members have diabetes or epilepsy?			

Please sign below to confirm all the above details are correct:

Completed By: _____ Date: _____

Client Signature: _____ Date: _____

Botulinum toxin label here: