**BOTOX / DERMAL FILLER**
**CLIENT INFORMATION & MEDICAL HISTORY**

**In order to provide you with the most appropriate treatment, please complete the following questionnaire. *All information is strictly confidential.***

## *PERSONAL HISTORY*

Today's date: _____

Name: _____

Date of Birth: _____ Age: _____

Occupation: _____

Home address: _____

_____

_____ Postcode: _____

Phone/Home: _____ Work: _____

Mobile: _____

Email address: _____

Emergency Contact: _____

Phone: _____

How were you referred to us? _____

Do you regularly sun bathe or use tanning salons?

Yes ☐ No ☐

If Yes, how often?

_____

## *MEDICAL HISTORY*

Are you currently under the care of a physician?

Yes ☐ No ☐

If yes, for what:

_____

_____

Do you have any of the following medical conditions? ***Please tick all that apply***

Cancer ……. Yes ☐ No ☐

Herpes ……. Yes ☐ No ☐

Frequent cold sores …….. Yes ☐ No ☐

Seizure disorder …… Yes ☐ No ☐

Thyroid imbalance …… Yes ☐ No ☐

Diabetes …….. Yes ☐ No ☐

Arthritis …… Yes ☐ No ☐

Keloid scarring …….. Yes ☐ No ☐

Hepatitis / Type ____ ..... Yes ☐ No ☐

Blood clotting abnormalities .... Yes ☐ No ☐

High blood pressure …….. Yes ☐ No ☐

HIV/AIDS …… Yes ☐ No ☐

Skin disease / skin lesions …... Yes ☐ No ☐

Hormone imbalance …….. Yes ☐ No ☐

Any active infection …….. Yes ☐ No ☐

Do you have any other health problems or medical conditions? Please list:

_____

_____

_____

Have you ever had an allergic reaction? (List any and all that you have had and describe the reaction you experienced)

Food ..…… Yes ☐ No ☐ Reaction: _____

Animal Protein ……..…… Yes ☐ No ☐ Reaction: _____

Aspirin ……..…….. Yes ☐ No ☐ Reaction: _____

Lidocaine …… Yes ☐ No ☐ Reaction: _____

Hydrocortisone ….…… Yes ☐ No ☐ Reaction: _____

Hydroquinone ……..…….. Yes ☐ No ☐ Reaction: _____

Skin Bleaching agents ……..… Yes ☐ No ☐ Reaction: _____

***MEDICATIONS***

What oral prescription medications are you presently taking:

Birth control pills ☐

Hormones ☐

Others ☐

(It is required that you list all of them): _____

_____

_____

What antibiotics do you use to treat infections?

_____

_____

_____

Do you take any medications for heart conditions?

Yes ☐ No ☐

If yes, what?_____

_____

Are you taking any mood altering or anti-depression medication?

Yes ☐ No ☐

If yes, what?_____

_____

_____

What topical medications or creams are you currently using?

Retin A ☐

Others / Please list: _____

_____

_____

What herbal supplements do you use regularly? _____

_____

_____

***HISTORY***
***For our female clients:***

Are you pregnant or trying to become pregnant? Yes ☐ No ☐

Are you breast feeding? Yes ☐ No ☐

Are you using contraception? Yes ☐ No ☐

I certify that the preceding medical, medication and personal history statements are true and correct. I am aware that it is my responsibility to inform the doctor or other health professional of my current medical or health conditions and to update this history as needed. A current medical history is essential for the Doctor to execute appropriate treatment procedures.

I consent to before and after picture being taken Yes ☐ No ☐

I consent to my pictures being used for promotional purposes Yes ☐ No ☐

Signature: _____

Date: _____