Facial Aesthetics Medical History

Please Tick √

	Yes	No
Have you ever had any unusual response to eggs?	☐	☐
Are you pregnant or breastfeeding at present?	☐	☐
Have you previously been treated with dermal filler or botulinium toxin?	☐	☐
If yes, please specify:		
Do you have any permanent implant(s) at the site(s) to be treated?	☐	☐
Have you previously received any aesthetic treatments? (e.g. Laser, Peels, dremabrasion etc.)	☐	☐
Do you have or have you ever had any form of skin cancer?	☐	☐
Do you or have you had any skin lesions, any cutaneous (skin) infection or inflammatory problems (e.g. herpes, acne etc.)	☐	☐
If yes, please specify:		
Do you suffer from myasthenia gravis, lambert-eaton syndrome or blood coagulation disorders?	☐	☐
Are you taking any of the following medication, aminoglycoside antibiotics, anaesthetics, muscle relaxants or beta blockers?	☐	☐

	Yes	No
Do you suffer from allergies, in particular allergies to Hyaluronic Acid or Lidocaine?	☐	☐
If yes, please specify:		
Have you a history of severe allergy / anaphylaxis?	☐	☐
Have you previously experienced a hypersensitivity to any dermal filler product?	☐	☐
Are you taking aspirin, steroids or anticoagulants (e.g. warfarin)	☐	☐
Have you received Roaccutane treatment in the past 12 months?	☐	☐
Do you suffer from any illness, e.g. angina, epilepsy, diabetes, hepatitis,	☐	☐
depression, stress, auto immune disease or disease affecting the immune system (e.g. rheumatoid arthritis)?	☐	☐
If yes, please specify:		
Do you suffer from recurrent sore throats	☐	☐
Are you currently undergoing dental surgery?	☐	☐
Do you suffer from keloid or hypertrophic scarring?	☐	☐
Are you prone to bruising?	☐	☐
Have you recently been exposed to the sun or sun beds?	☐	☐

Patient Name:__________________ Patient Signature: _____________ Date:____________