Medical history

Please complete the following medical questionnaire

Are you pregnant or breast feeding? Y ○ N ○

Have you a history of severe allergy/anaphylaxis? Y ○ N ○

Are you currently receiving any medical treatment? Y ○ N ○

If yes, please give more details _____

_____

Have you previously received any aesthetic treatments (e.g. laser, peels, dermabrasion etc.) Y ○ N ○

If yes, please give more details _____

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Have you had any treatment with dermal fillers, absorbable dermal fillers, semi-permanent dermal fillers or botulinum toxin? Y ○ N ○

If yes, which treatment did you receive, what areas were treated and when? _____

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Have you ever suffered from auto-immune disease or disease affecting the immune system? Y ○ N ○

Do you have any cutaneous (skin) infection or inflammatory problems (e.g. herpes, acne etc.)? Y ○ N ○

Are you currently taking any steroids, aspirin or anticoagulant (e.g. warfarin etc.)? Y ○ N ○

Do you suffer from acute rheumatic fever or recurrent sore throat? Y ○ N ○

Do you suffer from any allergies, in particular allergies to hyaluronic acid, amide type local anaesthetics or lidocaine? Y ○ N ○

Do you suffer from untreated epilepsy? Y ○ N ○

Do you tend to develop hypertrophic scarring? Y ○ N ○

Do you suffer from porphyria? Y ○ N ○

Do you suffer from cardiac conduction disorders? Y ○ N ○

If yes, please give details: _____

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If the answer is yes to any of the above, your practitioner may ask for further details.
Treatment may be refused if it is not considered in your own interest to proceed.