**MEDICAL QUESTIONNAIRE PRIOR TO BOTULINUM TOXIN & DERMAL FILLER TREATMENTS**

**Model Name: ……………………………… DOB: ……/……/……**

**Date: ……/……/……**

|  |  |  |  |
| --- | --- | --- | --- |
| **Please answer the following:** | **YES** | **NO** | **Please Specify:** |
| Do you have any Current health Problems? |  |  |  |
| Past medical History? |  |  |  |
| Previous Medical/Aesthetic Surgery (including  dermal fillers, Botox, skincare programmes) |  |  |  |
| Do you have any muscular or neurological disorder? |  |  |  |
| History of thrombosis (blood clot in blood vessels) ,  Bleeding disorders, excessive bruising? |  |  |  |
| Skin conditions, pigmentation, scarring? |  |  |  |
| History of Cold sores? |  |  |  |
| Referred/Under the care of psychologist,  Psychiatrist or counsellor? |  |  |  |
| Medications (including topical creams)  Aspirin, blood thinning tablets, high dose vitamin E, high dose omega 3, certain (aminoglycoside) antibiotics, muscle relaxant such as tubocuraine |  |  |  |
| Known allergies? Including allergic reactions to latex, dermal fillers, Botulinum toxins, anaesthesia  (including topical) |  |  |  |
| Recent sun exposure, use of sun beds/tanning? |  |  |  |
| Are you Pregnant/Breast feeding? |  |  |  |
| Do you smoke?  If yes how many cigarettes a day? |  |  |  |
| Anything else you may think might be relevant? |  |  |  |

I confirm that the health history is accurate and complete. I understand that withholding any information may be detrimental to my health during the procedure. If there is any change in my medical history, it is my responsibility to inform us.

**Model Signature: ……………………………… Date: ……/……/……**