MEDICAL HISTORY FORM

Title: (Ms/Miss/Mrs/Mr)

First Name: Last Name:

Date of Birth: Phone Number:

Email Address:

Address: Postcode:

Your local GP practice name:

GP's Address:

GP's Phone Number:

MEDICAL HISTORY FORM	YES	NO
Have you had any previous medical problems?		
If yes, please specify:		
Are you currently receiving any medical treatment?		
If yes, please specify:		
Do you have any allergies (e.g. asthma, any medication, food, cosmetics, latex)?		
If yes, please specify:		
Are you pregnant or breastfeeding?		
If yes, please specify:		

Do you suffer from an autoimmune disease or one that affects the immune system?		
If yes, please specify:		
Do you suffer from hepatocellular insufficiency*? *Liver failure		
If yes, please specify:		
Do you often suffer from angina and/or rheumatism on a regular basis?		
If yes, please specify:		
Do you suffer from a disease affecting the thyroid gland?		
If yes, please specify:		
Do you suffer from epilepsy?		
If yes, please specify:		
Do you suffer from epidermal reactions, herpetic, or infectious type (herpes, acne, ...)?		
If yes, please specify:		
Do you suffer from skin infections?		
If yes, please specify:		
Do you have any scarring problems?		
If yes, please specify:		

Have you had aesthetic treatments?		
If yes, please specify:		
Have you had any previous dermal filler injections?		
If yes, please specify and give the date of the injection **(month and year):**		
Do you know the name of the product injected?		
If **yes**, please **circle** or **underline** using the list of common names below **Name of the product:** Sculptra, Radiesse, Artecoll, Belotero, Collagene, Esthelis, Dermalive, Surgiderm, Hylaform, Juvederm, Restylane, Perlane, Silicone OR other. If **'other'**, please provide the name here:		
Did you have any side effects after the injection?		
If yes, please specify:		
Do you have any hypersensitivity/allergy to any ingredients present in the product?		
If yes, please specify:		

Patient name:

Patient signature: **Date:**