



Simply Fox

## Medical History Form

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Street Address:** \_\_\_\_\_

**Town:** \_\_\_\_\_ **Postcode:** \_\_\_\_\_

**Contact number:** \_\_\_\_\_ **Mobile:** \_\_\_\_\_

**Email:** \_\_\_\_\_

**G.P. Name and address:** \_\_\_\_\_

	Yes	No
Are you attending or receiving treatment from a doctor or specialist If yes, please specify:	<input type="radio"/>	<input type="radio"/>
Are you taking any medication, or herbal remedies (including antibiotics, anticoagulants, muscle relaxants, St Johns Wart, Roaccutane)? If yes, please specify:	<input type="radio"/>	<input type="radio"/>
Have you undergone any major surgery in the last 12 months? If yes, please specify:	<input type="radio"/>	<input type="radio"/>
Are you currently undergoing dental surgery? If yes, please specify:	<input type="radio"/>	<input type="radio"/>
Are you taking blood thinning medication (Aspirin, Plavix, Warfarin) ?	<input type="radio"/>	<input type="radio"/>
Are you allergic to local anaesthetic injections, lignocaine, adrenaline or EMLA/ANESTOP cream?	<input type="radio"/>	<input type="radio"/>
Do you have any known allergies or a history of anaphylaxis? If yes, please specify:	<input type="radio"/>	<input type="radio"/>
<b>Have you suffered from or had any of the following conditions?</b>		
Heart Problems including an irregular heartbeat or angina	<input type="radio"/>	<input type="radio"/>
High or Low Blood Pressure or circulation problems including Raynaud's Syndrome	<input type="radio"/>	<input type="radio"/>
Epilepsy/Blackouts/fainting	<input type="radio"/>	<input type="radio"/>
Blood disorders/leukaemia/lymphoma/anaemia	<input type="radio"/>	<input type="radio"/>
Autoimmune disease	<input type="radio"/>	<input type="radio"/>
Diabetes	<input type="radio"/>	<input type="radio"/>



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Contact Dermatitis/Eczema	<input type="radio"/>	<input type="radio"/>
Keloids (hypertrophic scarring) or recent scar tissue (6 months)	<input type="radio"/>	<input type="radio"/>
Easy Bruising	<input type="radio"/>	<input type="radio"/>
Facial Herpes, Cold Sores or acne	<input type="radio"/>	<input type="radio"/>
Skin Cancer	<input type="radio"/>	<input type="radio"/>
Psychiatric illness/depression	<input type="radio"/>	<input type="radio"/>
Do you smoke?	<input type="radio"/>	<input type="radio"/>
Do you use sunbeds or sunbathe?	<input type="radio"/>	<input type="radio"/>
Are you pregnant/planning pregnancy/engaged in IVF treatment or are you breast feeding? If yes, please specify:	<input type="radio"/>	<input type="radio"/>
Have you had a consultation or been treated with a dermal filler or Botox® before? If yes, please specify:	<input type="radio"/>	<input type="radio"/>
Have you had an allergic reaction to any dermal filler or Botox® product? If yes, please specify:	<input type="radio"/>	<input type="radio"/>
Have you had a consultation or had plastic surgery or planning to have surgery including permanent implants, laser resurfacing or skin peels? If yes, please specify:	<input type="radio"/>	<input type="radio"/>
Any other medical conditions that you feel may be relevant, please specify:		

### What are your expectations of treatment? (please discuss with your practitioner)

I confirm the health history is accurate and complete. I understand that withholding any medical information may be detrimental to my health and safety during the procedure which the practitioner agrees to undertake. If there are any changes in my medical history, it is my responsibility to advise the practitioner before any further treatments are carried out. I agree that I understand the treatment I am having today and the possible risks associated with these procedures.

Patient Signature: \_\_\_\_\_

Date \_\_\_\_\_

Practitioner Signature: \_\_\_\_\_

Date \_\_\_\_\_