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:	○	○
Are you taking any medication, or herbal remedies (including antibiotics, anticoagulants, muscle relaxants, St Johns Wart, **Roaccutane**)? If yes, please specify: Have you taken Roaccutane in the last 6 months?	○	○
Have you undergone any major surgery in the last 12 months? If yes, please specify:	○	○
Are you currently undergoing dental surgery? If yes, please specify:	○	○
Are you taking blood thinning medication (Aspirin, Rivaroxiban, Warfarin) ?	○	○
Are you allergic to local anaesthetic injections, lignocaine, adrenaline or EMLA/LMX cream?	○	○
Do you have any known allergies or a history of anaphylaxis? Especially bee stings or eggs? If yes, please specify:	○	○
Have you suffered from or had any of the following conditions?		
Heart Problems including an irregular heartbeat or angina	○	○
High or Low Blood Pressure or circulation problems including Raynaud's Syndrome	○	○
Epilepsy/Blackouts/fainting	○	○
Blood disorders/leukaemia/lymphoma/anaemia	○	○
Autoimmune disease /Immunosuppressed in any way eg on high dose steroids, methotrexate or recent chemotherapy?	○	○
Diabetes /MS or any neurological conditions?	○	○
Contact Dermatitis/Eczema/Skin conditions	○	○
Keloids (hypertrophic scarring) or recent scar tissue (6 months)	○	○

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	Yes	No
Easy Bruising / Blood disorders?	○	○
Facial Herpes, Cold Sores or acne	○	○
Skin Cancer or any other history of cancer?	○	○
Psychiatric illness/depression/ anxiety	○	○
Do you smoke?	○	○
Do you use sunbeds or sunbathe?	○	○
Are you pregnant/planning pregnancy/engaged in IVF treatment or are you breast feeding? If yes, pleas specify:	○	○
Have you had a consultation or been treated with a dermal filler or Botox before? If yes, please specify:	○	○
Have you had an allergic reaction to any dermal filler or Botox product? If yes, please specify:	○	○
Have you had a consultation or had plastic surgery or planning to have surgery including permenant implants, laser resurfacing or skin peels? If yes, please specify:	○	○

Any other medical conditions that you feel may be relevant, please specify:

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

E.g areas you would like treated?

I confirm the health history is accurate and complete. I understand that witholding 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 and the possible risks associated with these procedures.

Patient Signature: _____ Date _____

Practitioner Signature: _____ _____ Date _____