

Medical History Form – COVID 19 version

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: Have you taken Roaccutane in the last 6 months?	<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, Rivaroxiban, Warfarin) ?	<input type="radio"/>	<input type="radio"/>
Are you allergic to local anaesthetic injections, lignocaine, adrenaline or EMLA/LMX cream?	<input type="radio"/>	<input type="radio"/>
Do you have any known allergies or a history of anaphylaxis? Especially bee stings or eggs? If yes, please specify:	<input type="radio"/>	<input type="radio"/>

Have you suffered from or had any of the following conditions?

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 /Immunosuppressed in any way eg on high dose steroids, methotrexate or recent chemotherapy?	<input type="radio"/>	<input type="radio"/>
Diabetes /MS or any neurological conditions?	<input type="radio"/>	<input type="radio"/>
Contact Dermatitis/Eczema/Skin conditions	<input type="radio"/>	<input type="radio"/>
Keloids (hypertrophic scarring) or recent scar tissue (6 months)	<input type="radio"/>	<input type="radio"/>

	Yes	No
Easy Bruising / Blood disorders?	<input type="radio"/>	<input type="radio"/>
Facial Herpes, Cold Sores or acne	<input type="radio"/>	<input type="radio"/>
Skin Cancer or any other history of cancer?	<input type="radio"/>	<input type="radio"/>
Psychiatric illness/depression/ anxiety	<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"/>

COVID 19 specific. If you answer yes to any of these questions, please call the clinic prior to attending as your appointment may need to be rescheduled.

Are you currently or have you been shielding or are you deemed as high risk from COVID 19?	<input type="radio"/>	<input type="radio"/>
Have you got or recently had a temperature over 37.8c?	<input type="radio"/>	<input type="radio"/>
Do you have a new and persistent cough?	<input type="radio"/>	<input type="radio"/>
Has your GP deemed you a moderate risk of COVID 19 or have you been diagnosed with COVID 19?	<input type="radio"/>	<input type="radio"/>
Have you noticed any change in your sense of taste and/or smell?	<input type="radio"/>	<input type="radio"/>
Have you or anyone you lived with or had close contact with had any of these symptoms or been diagnosed with COVID 19 in the last 2 weeks?	<input type="radio"/>	<input type="radio"/>
Do you have any other symptoms of feeling unwell such as fatigue, confusion, sore throat, vomiting and diarrhoea?	<input type="radio"/>	<input type="radio"/>

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

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, and the possible risks associated with these procedures.

Patient Signature: _____

Date _____

Practitioner Signature: _____

Date _____