Eyelipsia
Aesthetics

Medical History Form for Skin Rejuvenation Treatments

This questionnaire will form part of your confidential clinical records

Title Mr/Mrs/Ms/Miss other:

Surname: _____

Forenames: _____

Date of birth: _____

Sex M/ F

Address: _____

Postcode:_____

Are you an expectant mother ☐
Are you taking the contraceptive pill ☐
Are you breastfeeding ☐
Are you taking HRT ☐

Previous medical conditions and treatment, please tick if you have had:

☐ Asthma, eczema or other allergic disease
☐ Rheumatic fever or Chorea (St Vitus' Dance)
☐ Any blood borne diseases
☐ Any heart conditions such as rheumatic fever, angina, murmur or valve problems
☐ A stroke or blood pressure problems
☐ Any neurological conditions such as Bell's Palsy Myasthenia Gravis, Lambert-Eaton Syndrome, Motor Neuron Disease or Multiple Sclerosis? If Yes please give details:

☐ Any skin problems such as herpes, infections or cold sores
☐ An allergic reaction to substances or drugs such as foods, latex or antibiotics
☐ Anaphylactic shock
☐ Skin cancer
☐ Keloid or hypertrophic scarring
☐ Roaccutane (acne treatment drug) in the last 12 months
☐ Steroids within the last two years
☐ A valve replacement, hip replacement or implant

☐ A general anaesthetic, sedation
☐ An operation or surgical treatment
☐ A period as an in-patient at a hospital
☐ Any previous skin rejuvenation treatments, if so please give details:
☐ Any problems with skin rejuvenation treatments, if yes please give details:
☐ Any other illnesses or treatments, if yes please give details:

Current medical status, please tick if you:

☐ Are currently seeing a doctor or attending a clinic
☐ Carry a warning card
☐ Have taken any of the following within the last 3 days (please circle)
I. Aminoglycoside antibiotics (Gentamicin, Neomycin, Streptomycin, Amikacin or Tobramycin)
II. Spectinomycin
III. Penicillamine (anti-rheumatic)
IV. Quinine (anti-malarial)
V. Calcium Channel blockers (Diltiazem, Nifedipine or Verapamil)
VI. Non-depolarising muscle relaxants

Are taking any other pills, medicines or tablets including aspirin or NSAIDS (eg Ibuprofen, Naproxen, Ponstan)
☐ Are using any other form of medication/ointment or inhaler
☐ Are you using any complimentary therapies or supplements such as St Johns Wort or Vitamin E, if yes please give details:

☐ Suffer from fainting attacks
☐ Bleed or bruise easily
☐ Have diabetes or epilepsy
☐ Currently have any cold sores or skin infections
☐ Have recently been exposed to the sun or sun beds
☐ Have any other diseases or medical conditions, if so please give details:

Completed by:_____

Signature: _____

Date: _____

MH review by: _____ Date: _____