BEAUMAC HAIR/BEAUTY/ACADEMY
SPMU/DERMAL FILLERS
MEDICAL HISTORY FORM

First Name

Last Name

YOUR ADDRESS

D.O.B

Age

Gender ☐ Male ☐ Female

Address

Phone number

GP Details

Occupation

Height

Weight

Do you smoke?

Do you drink alcohol?

Do you exercise regularly?

Do you follow any special diet?

Are you pregnant or breast feeding ☐ YES ☐ NO

Are you trying to conceive or undergoing IVF? ☐ YES ☐ NO

Do you currently have or had you ever had:

Pigment disorder ☐ YES ☐ NO

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Increased light sensitivity? ☐ YES ☐ NO

Herpes, shingles, chicken pox? ☐ YES ☐ NO

Skin cancer? ☐ YES ☐ NO

Keloid scarring? ☐ YES ☐ NO

Acne, psoriasis or other active skin conditions? ☐ YES ☐ NO

Amyotrophic lateral sclerosis, myasthenia gravis, Eaton lambert syndrome? ☐ YES ☐ NO

Multiple sclerosis? ☐ YES ☐ NO

Impaired swallowing or dysphasia? ☐ YES ☐ NO

Angina, Heart attack? ☐ YES ☐ NO

High/low bp? ☐ YES ☐ NO

Emotional or neurological disorders – depression, epilepsy, ME ? ☐ YES ☐ NO

Migraine? ☐ YES ☐ NO

Asthma? ☐ YES ☐ NO

Diabetes? ☐ YES ☐ NO

Thyroid issues? ☐ YES ☐ NO

Auto immune disease – HIV, lupus? ☐ YES ☐ NO

Nose bleeds, frequent bruising, bleeding or coagulation disorders? ☐ YES ☐ NO

Are you aware of any hereditary conditions? ☐ YES ☐ NO

Allergies or hypersensitivities? ☐ YES ☐ NO

Hospitalised due to severe allergic reaction? (if you have an allergy card please show this to the practitioner) ☐ YES ☐ NO

Desensitisation treatment ☐ YES ☐ NO

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Have you recently or are currently taking any of the following:

coagulation inhibitors, antibiotics, steroids, aspirin, warfarin, ibuprofen, vitamins and supplements, roaccutane, isotretinoin for acne in the last year ☐ YES ☐ NO

Have you recently had immunisations ☐ YES ☐ NO

Had major surgery in last six weeks ☐ YES ☐ NO

Are you currently or planning to have any dental treatments ☐ YES ☐ NO

Have you had any facial treatments – laser, skin peel, facelift, IPL, skin resurfacing or ☐ YES ☐ NO

Do you have blood or needle phobias ☐ YES ☐ NO

Do you bruise easily ☐ YES ☐ NO

Have you recently been exposed to sunbeds/lamps ☐ YES ☐ NO

Are you allergic to chicken or eggs ☐ YES ☐ NO

Have you ever had a local anaesthetic injection at the dentist ☐ YES ☐ NO

Have you ever had a reaction to anaesthetic ☐ YES ☐ NO

Have you had anti-wrinkle injections before ☐ YES ☐ NO

If yes how long ago

Did you experience any side effects or reaction ☐ YES ☐ NO

Have you had dermal filler before ☐ YES ☐ NO

If yes how long ago

Do you know the name filler was used?

Did you have any side effects or reaction ☐ YES ☐ NO

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Do you have permanent facial implants☐ YES☐ NO

Are you allergic to chicken or eggs☐ YES☐ NO

Have you ever received a local anaesthetic at your dentist☐ YES☐ NO

Have you had anti-wrinkle injections before☐ YES☐ NO

Have you had anti-wrinkle injections before☐ YES☐ NO

If yes how long ago?

Did you experience any side effects or reaction☐ YES☐ NO

Do you have permanent facial implants☐ YES☐ NO

Did you experience any side effects or reactions☐ YES☐ NO

Please provide information on areas of your face you have concerns over and your expectations regarding treatment outcomes

Do you have any further concerns regarding the treatment or is there anything else not covered above you would like to mention?

Patient consent form for injections (please initial where indicated)

I have been made aware of the products used during my treatment and all my questions answered to my satisfaction. I have been advised of potential side effects or reactions, e.g. Redness, swelling, pain, itching bruising and tenderness in the treated area. I understand that these should be mild to moderate, are normal and should clear within a few days.

Other reactions are rare, however, approximately 1 in 10,000 people treated with dermal filler will experience allergic reaction. This will usually be swelling and firmness in the treated area and sometimes in surrounding tissue, redness, tenderness and in rare cases acne like symptoms. These reactions can occur at any time between a few days and several weeks after

treatment. These are usually mild to moderate and last no more than a couple of weeks but in extremely rare cases lump formations like granulomas can persist for months. ☐

In very rare cases (less than 1 in 15,000) prolonged firmness, abscess or greyish colouration has occurred in treatment area. These can develop within weeks of treatment and may persist for several months. Much rarer than this is scabbing and slough (shedding) of tissue which can result in shallow scarring, there have been reports of blindness occurring after dermal fillers in areas including glabellar frown lines, under the eyes and temple. ☐

The practitioner has made me fully aware of expected outcomes and risks associated with muscle relaxation treatments based on the current product summery of product characteristics (SmPC). We have discussed realistic outcomes regarding results and duration of treatments and effects as well as possible side effects both relation to the injection area and other common and uncommon side effects like headaches, muscle activity disorders (raised eyebrows) feeling of heaviness in upper part of face, accumulation of fluid In the eyelid, drooping eyelid, eye pain, blurred vision, fainting, tinnitus, nausea, dizziness, muscle twitching, muscle cramps, localised facial muscle weakness (drooping eyebrow), dry mouth, flu like symptoms, influenza, bronchitis, inflamed nose and throat, infection, excessive muscle weakness and difficulty swallowing. In the event of an extreme adverse reaction I have been advised by practitioner to seek medical advice immediately. ☐

The information I have provided is accurate to the best of my knowledge ☐

I have not, knowingly withheld any medical information. Initial…… I agree to inform the practitioner of any changes in medications or health ☐

I have read and fully understand all the information given to me regarding the treatment process and possible complications. I have discussed this with the practitioner and given my full consent for treatment to be carried out ☐

I consent to the use of topical anaesthetic ☐ YES ☐ NO

I consent to lidocaine ☐ YES ☐ NO

I consent to the use of before and after pictures being used ☐ YES ☐ NO

ENTER FULL NAME ☐

TODAY'S DATE

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MEDICAL HISTORY FORM

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