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New Patient Information

Patient details

Patient name _____

Patient DOB _____ Patient postcode _____

Patient email address _____

Patient address _____

Patient mobile phone _____

Patient Medical History

Do you have any Allergies? Please describe if you do. _____

Do you take any medications regularly? Please list if you do. _____

Do you take any "blood thinning" medication (warfarin, clopidogrel, aspirin, apixaban, dabigatran, rivaroxaban)? YES NO

Do you have any significant medical conditions? Please list. _____

Are you pregnant, or trying to conceive? YES NO Are you breastfeeding? YES NO

Do you suffer from cold-sores? YES NO

Have you been previously diagnosed with a neuromuscular condition, such as myasthenia gravis or Eaton-Lambert syndrome? YES NO

Have you ever had cosmetic treatments before? Please describe. _____

"Botox" (anti-wrinkle injections) ☐ "Filler" (lips/cheeks etc) ☐

Permanent prosthetics (filler or other) ☐ Cosmetic surgery ☐

If you have had cosmetic treatments before, did you have a reaction? _____