



ETERNAL YOUTH

MEDICAL AESTHETICS

MEDICAL QUESTIONNAIRE

PRIOR TO BOTULINUM TOXIN (BOTOX) &
DERMAL FILLER TREATMENTS

Patient Name:

D.O.B:

Address:

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.....

Date:

Please answer the following...

Do you have any current health problems.
(if YES please specify below)

Yes

No

Past medical history

Previous Medical/Aesthetic Surgery
(including dermal filler, Botox, skincare programmes)

Please answer the following...

Any muscle or nervous system disorders?
(if YES please specify below)

Yes

No

Any history of thrombosis, bleeding disorders,
easy bruising? (if YES please specify below)

Yes

No

Skin conditions, pigmentation, scarring?
(if YES please specify below)

Yes

No

Cold sores? Last episode?
(if YES please specify below)

Yes

No

Referred/Under the care of psychologist,
psychiatrist or counsellor? (if YES please
specify below)

Yes

No

Medications (including topical creams and any
over the counter or herbal preparations)

Yes

No

Known allergies? Including allergic
reactions to latex, dermal fillers, Botulinum
toxins, anaesthesia (including topical)

Yes

No

Recent sun exposure, use of sun beds/
tanning?

Yes

No

Pregnant/Breast feeding? Yes No

Smoker? Yes No

Anything else you may think is relevant?

*I confirm that the health history is accurate and complete.
I understand that withholding any information may be detrimental
to my health during the procedure. If there is any change in my
medical history, it is my responsibility to inform the practitioner.*

Patient Signature:

Date:

Practitioners Signature:

Date: