Client **Information**

ABOUT YOUR HEALTH

1. Are you allergic to anything (including anaesthetics/ adrenaline/ vitamin E or derivatives/ lidocaine)? ☐ YES / ☐ NO
   If yes, please specify: _____
2. Have you ever had a dental block before (to numb your mouth)? ☐ YES / ☐ NO
3. Do you suffer from epilepsy? ☐ YES / ☐ NO
4. Have you ever had cold sores? ☐ YES / ☐ NO
   If yes, when was the last episode? _____
5. Do you smoke? ☐ YES / ☐ NO
6. Do you have any serious health problem, including any blood borne diseases or blood disorders? ☐ YES / ☐ NO
   If yes, please specify: _____
7. Have you had any minor or major surgery, including cosmetic surgery? ☐ YES / ☐ NO
   If yes, please specify: _____
8. Are you currently taking any medication or health supplements (prescribed or otherwise)? ☐ YES / ☐ NO
   If yes, please list: _____
9. Are you currently pregnant or planning a pregnancy in the next 3 months? ☐ YES / ☐ NO
10. Are you currently breastfeeding? ☐ YES / ☐ NO
11. Have you ever received Botulinum Toxin Type A or other anti-wrinkle treatments before? ☐ YES / ☐ NO
    If yes, in which area of the face? _____
12. Have you ever received dermal fillers before? ☐ YES / ☐ NO
    If yes, in which area of the face? Which product? _____
13. Do you bruise easily? ☐ YES / ☐ NO
14. Have you had a Tetanus/ whooping cough booster within the last 6 weeks? ☐ YES / ☐ NO
15. Do you currently suffer any dental or sinus conditions? ☐ YES / ☐ NO
    If yes, please specify: _____
16. Do you have a history of keloid scars? ☐ YES / ☐ NO
    If yes, please specify: _____
17. Do you intend to travel internationally in the following 2 weeks? ☐ YES / ☐ NO

Please note: If your situation or medical condition ever changes in the future please ensure you advise us prior to receiving treatments.