PDRN Polynucleotide - Lumi Eyes / SDNA

Medical History Form:

Please do not book your appointment 2 weeks prior and 3 weeks post covid19 vaccine.

Full Name: ___________________________________ Date of Birth: ________________
Street Address: ____
Town: ____ Postcode: ____________________
Contact number: ________________________ Mobile: _____________________________
Email: ____
Please Confirm if you would like to sign up to our email offers? Yes/No

G.P. Name and Address:____

Are you attending or receiving treatment from a doctor or specialist If yes, please specify?

………

Are you taking any medication, or herbal remedies (including antibiotics, anticoagulants, muscle relaxants, St Johns Wart, Roaccutane)? If yes, please specify?

………

Have you undergone any major surgery in the last 12 months? If yes, please specify?

………

Are you currently undergoing dental surgery? If yes, please specify?

………

Are you taking blood thinning medication (Aspirin, Plavix, Warfarin)? If yes, please specify?

………

Are you allergic to local anaesthetic injections, lignocaine, adrenaline or EMLA/ANESTOP cream? If yes, please specify?

………

Do you have any known allergies or a history of anaphylaxis? If yes, please specify?

……

Have you suffered from or had any of the following conditions?

Heart Problems including an irregular heartbeat or angina? If Yes, Please Specify?

……..

High or Low Blood Pressure or circulation problems including Raynaud's Syndrome Epilepsy/Blackouts/fainting? If Yes, Please Specify?

……..

Blood disorders/leukaemia/lymphoma/anaemia? If Yes, Please Specify?

……..

Autoimmune disease? If Yes Please Specify?

……..

Diabetes? If Yes, Please Specify?

…….

Contact Dermatitis/Eczema? If Yes Please Specify?

…….

Keloids (hypertrophic scarring) or recent scar tissue in the past 6 Months? If Yes Please Specify:

…….

Bruise easily?: If Yes Please Specify:

……

Facial Herpes, Cold Sores, or Acne? If Yes Please Specify:

……..

HIV: (This will not affect if you can have the treatment). Yes/No?

Are you, or any of your household showing any symptoms of covid-19? Yes/No?

Skin Cancer? If Yes Pease Specify:

………

Are you pregnant/planning pregnancy/engaged in IVF treatment or are you breast Feeding? If yes, please specify:

……..
Have you had a consultation or been treated with a dermal filler or Botox® before? If yes, please specify?

……..

Have you had an allergic reaction to any dermal filler or Botox® product? If yes, please specify:

……
Have you had a consultation or had plastic surgery or planning to have surgery including permanent implants, laser resurfacing or skin peels? If yes, please specify:

……
Any other medical conditions that you feel may be relevant, please specify:

……
Psychiatric illness/Depression? Yes/No?

Do you smoke? Yes/No

Do you use sunbeds or sunbathe? Yes/No?

What are your expectations of this treatment?

……..

Do you show any symptoms of Covid 19? If yes please do not attend your appointment.

I confirm the health history is accurate and complete. I understand that withholding any medical information may be detrimental to my health and safety during the procedure which the practitioner agrees to undertake. If there are any changes in my medical history, it is my responsibility to advise the practitioner before any further treatments are carried out. I agree that I understand the treatment I am having today, and the possible risks associated with these procedures.

Client Signature: ____

Date ______________________________

Practitioner Signature: ____

Date ______________________________