|  |  |  |
| --- | --- | --- |
| Name: | DOB | Date |

|  |  |
| --- | --- |
| Address | Phone  |
|  | Email |

|  |  |  |  |
| --- | --- | --- | --- |
| **Previous Medical Conditions/Treatments** | **Yes** | **No** | **Details** |
| Cold Sores? |  |  |  |
| Jaundice, Hepatitis, Liver or Kidney disease? |  |  |  |
| Asthma, Eczema or other allergic disease? |  |  |  |
| Any blood-borne diseases? |  |  |  |
| Angina, murmur, valve or other heart conditions? |  |  |  |
| A stroke or any other blood pressure problems? |  |  |  |
| Any neurological conditions such as epilepsy, Bell’s Palsy, MS, Chorea or Myasthenia Gravis? |  |  |  |
| Allergic to latex, antibiotics, foods, drugs/substances? |  |  |  |
| Any recent vaccinations, cortisone injections or steroids? |  |  |  |
| Replacements, implants, operations, X-rays recently? |  |  |  |
| Any other diseases, illnesses or treatments? |  |  |  |
| Have you ever had cancer? |  |  |  |
| **Current Medical Status** |  |  |  |
| Are you receiving treatment from a doctor, hospital or specialist? |  |  |  |
| Carry a warning card, EpiPen, had anaphylaxis reaction? |  |  |  |
| Taking medicines, pills, tablets, ointments or inhalers? |  |  |  |
| Use therapies or supplements such as St. John’s Wort? |  |  |  |
| Do you bruise or bleed easily? |  |  |  |
| Any auto-immune disease, including lupus? |  |  |  |
| Any circulative problems or varicose veins? |  |  |  |
| Any endocrine disorders? (diabetes, thyroid) |  |  |  |
| Do you follow a healthy diet? |  |  |  |
| Do you take regular exercise? |  |  |  |
| Fluid intake – Water, Alcohol, Tea, Coffee? |  |  |  |
| Have you had electrical facial treatments before? |  |  |  |

***I hereby certify that***

* ***I have been fully informed of the nature and purpose of the procedure, expected outcome and possible side effects***
* ***I understand that there can be no guarantee or assurance as to the final result that may be obtained***
* ***If Botolium Toxin top ups required this MUST be arranged with your practitioner at a mutually suitable time/price within 2 weeks of administering of product(s)***
* ***I have been given the opportunity to ask questions and hereby certify that I have read and fully understood the contents of this consent form***
* ***I have received an aftercare sheet and agree to follow the recommendations***

I consent to receiving \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ and to the best of my knowledge the above answers are correct and I have not withheld any information that may be relevant to my treatment. I acknowledge that photographs will be taken before and after treatments and understand the side effects associated with this treatment

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Practitioner’s Name and Signature Client Signature