solasdermatology & LASER CLINIC

BOTOX MEDICAL HISTORY

Please complete the following medical questionnaire:

(Circle Y = yes or N = no)

Are you pregnant or breastfeeding **Y** **N**

Have you a history of severe allergy/anaphylaxis? **Y** **N**

Are you currently receiving any medical treatment? **Y** **N**

Have you previously received any anaesthetic treatments,
(e.g. laser, peels, dermabrasion etc?) **Y** **N**

If yes, please give more details: ____

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Have you had any dermal filler treatment of botulinum toxin? **Y** **N**
If yes, which treatment did you received and what areas were treated? _____

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Have you ever suffered from auto-immune disease or disease
affecting the immune system? **Y** **N**

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Do you have any skin infection or inflammatory problems,

(eg. herpes, acne etc)? **Y** **N**

Do you scare easily? **Y** **N**

Are you currently taking any steroids, Aspirin or anticoagulant

(eg Warfarin etc)? **Y** **N**

Do you suffer from rheumatoid arthritis or recurrent sore throat? **Y** **N**

Do you suffer from any allergies? **Y** **N**

If yes, please give details____

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If the answer is yes to any of the above, your practitioner may ask for further details. Treatment may be refused if it is not considered in your own interest to proceed.