Alexander Aesthetics

PERSONAL INFORMATION AND CONTACT DETAILS

DERMAL FILLERS

Title _____

First Name _____

Surname _____

D.O.B _____

Address _____

_____

Postcode _____

Tel Nos _____

_____

Email _____

Other treatments would be interested in at a later date (please tick)

Botox – Frown [ ] Forehead [ ] Crow's Feet [ ]

Fillers – Lips [ ] Naso-labial folds (nose to mouth lines) [ ]

Fillers – Frown [ ] Peri-oral lines (smokers lines) [ ]

Dermal Roller [ ] Skin Peels/ Microdermabrasion [ ]

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Medical History - Dermal Fillers

Name: _____ D.O.B: _____

Please answer yes or no to the following questions and give more details as required. If there are any questions you don't understand or have any concerns, please ask your practitioner.

Is there any chance you could be pregnant? _____ Y/N

Are you breastfeeding? _____ Y/N

Do you have any medical problems? _____ Y/N

Please give details _____

Are you taking any medication? _____ Y/N

Please give details _____

Have you taken aspirin, warfarin or ibuprofen within the last week? _____ Y/N

Are you undergoing any dental treatment? _____ Y/N

Do you have any allergies? _____ Y/N

Please give details _____

Have you ever had a severe allergic reaction (anaphylaxis)? _____ Y/N

Have you ever had facial surgery? _____ Y/N

Have you taken Roaccutane (for acne) in the past 12 months? _____ Y/N

Do you suffer from keloid scarring? (overgrowth of scar tissue)? _____ Y/N

Are you prone to bruising? _____ Y/N

Do you suffer from herpes (cold sores)? _____ Y/N

Have you had any skin peels, injections or laser treatment? _____ Y/N

Please give details _____

Have you previously had filler treatments? _____ Y/N

Please give details _____

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Do you suffer from any skin infections/problems? _____ Y/N

Please give details _____

Do you have a history of auto-immune disease? _____ Y/N

I confirm that I have answered this to the best of my ability.

First Name _____ Surname _____ (Please print)

Signature _____ Date _____/_____/_____

Practitioner Name: _____Practitioner signature: _____

INFORMED CONSENT – DERMAL FILLERS

- I confirm that I consent to receiving treatment using hyaluronic acid filler.
- I have been given sufficient information to enable me to understand the use of the product.
- Some redness, swelling, haematomas or bruising may occur following treatment. These will usually resolve within a few days.
- As with all injectable treatments, there is a minimal risk of infection, vessel occlusion, granuloma, abscess formation and hypersensitive reaction.
- I agree to the use of a topical anaesthetic cream.
- I agree to follow the post-treatment advice given to me by my practitioner.
- I understand that the practice of medicine and surgery is not an exact science and therefore that no guarantee can be given as to the results of the treatment referred to in this document. I accept and understand that the goal of this treatment is improvement, not perfection, and that there is no guarantee that the anticipated results will be achieved.

I_____ (Please print name)

Consent to the treatment detailed on this form.

Signed_____ Date: _____/_____/_____

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TREATMENT RECORD – FOR PRACTITONER USE ONLY

Date___/___/___

Areas Treated: _____

Product Type: _____

Lot No: _____

Notes: _____

_____

Date___/___/___

Areas Treated: _____

Product Type: _____

Lot No: _____

Notes: _____

_____