Personal Information Document

Name: Address: Date of Birth:	GP Surgery:

Medical Questionnaire – *Please answer honestly as any important information that may be withheld, could affect the outcome and safety of your treatment.*

	YES	**NO**	**NA**	**Details**
Are you pregnant or breastfeeding? Or is there a possibility of pregnancy?				
Do you currently have an illness with a temperature, fever or infection?				
Have you got any known allergies?				
Do you take any regular medication either prescription or over the counter?				
Do you have a known bleeding disorder or are you on anticoagulant treatment? (Blood thinning medication such as; Enoxaparin, Warfarin, Fragmin or Asprin)				
Have you ever had an adverse reaction from previous Botulinum A Toxin or Dermal Fillers?				
Do you have any existing medical conditions?				
Do you suffer with any neuromuscular disorders?				

**** IF YOU ANSWERED 'YES' TO ANY OF THE QUESTIONS ABOVE OR HAVE ANY CONCERNS YOU MUST DISCUSS THESE WITH YOUR NURSE PRACTITIONER BEFORE RECEIVING TREATMENT****

I confirm that I have answered the above questions honestly and any concerns have been discussed with me. I am aware and consent to my personal information and before and after photography being stored for legal purposes for up to 10 years I am aware they will be kept confidential.

Signed:..... Date: .....

Nurse Practitioner Name	Nurse Practitioner Signature		Date	Prescriber details
				Name
Brand Name	Batch No & Expiry Date		Total Units	Signature
		Exp:		