SLOANE MEDICAL PRACTICE

Sloane Medical Practice
82 Sloane Street, London SW1X 9PA
Telephone 020 7235 3002
Facsimile 020 7235 3721
Email info@sloanemedicalpractice.com
www.sloanemedicalpractice.com

Medical History

Date:

Name: _____ Ms/Miss/Mrs/Mr

Date of Birth: _____

Do you smoke?	Yes/No	How many per day:
If 'No', have you ever smoked	Yes/No	When did you give up:
Do you drink alcohol	Yes/No	If 'Yes', how many units per week:
Height:		Weight:
Are you trying to lose weight	Yes/No	If 'Yes', how much:
Do you have a special diet?	Yes/No	If 'Yes', please give detail:
Do you take regular exercise?	Yes/No	If 'Yes', please give detail:

Have you previously received any aesthetic treatments (e.g. laser, peels, dermabrasion etc.)? Yes/No
If yes, please give more detail

_____

Have you had any dermal filler treatment of botulinum toxin? Yes/No
If yes, which treatment did you receive, what areas and when:

_____

Are you currently receiving any medical treatment? Yes/No
If yes, please give more detail:

_____

Are you taking any dietary supplements or medications? Yes/No
If yes, please not them below:

_____

Have you had any previous surgery? Yes/No
If yes, please give details:

_____

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Have you ever suffered from any of the following?

Heart disease/angina	Yes	No	Diabetes	Yes	No
Thyroid Problems	Yes	No	Stomach ulcer/colitis	Yes	No
Arthritis	Yes	No	Skin disease (eg herpes of acne)	Yes	No
Asthma/Bronchitis	Yes	No	HIV/hepatitis	Yes	No
Convulsions	Yes	No	Glaucoma/cataract	Yes	No
Depression	Yes	No	Venereal disease	Yes	No
High/low blood pressure	Yes	No	Bell's facial palsy	Yes	No
Facial cold sores	Yes	No	Phlebitis	Yes	No
High/low blood pressure	Yes	No	Hypoglycemia	Yes	No
Are you pregnant or breast feeding?	Yes	No	Have you a history of severe allergy / anaphylaxis to BOTOX® (botulinum toxin type A) or its excipients?	Yes	No
Have you a history of severe allergy/anaphylaxis?	Yes	No	Do you suffer from myasthenia gravis or Eaton Lambert Syndrome?	Yes	No

Do you have any neuromuscular disorders or defects? Yes/No
e.g. Myasthenia Gravis, Eaton Lambert or Amyotrophic Lateral Sclerosis

Do you suffer from bleeding disorder? e.g. haemophilia Yes/No

Have you had any previous surgery?
If yes, please give details:

Have you ever been admitted to hospital?
If 'Yes', please give details:

Are you currently undergoing desensitisation treatment? Yes/No
If yes, please give details:

Are you currently taking or have ever taken any of the following medications?

Laxatives/Vitamin E	Yes	No	St John's Wort	Yes	No
Hormones/Contraceptive Pill	Yes	No	Gentamcin/Neomycin	Yes	No
Steroids/gold injections	Yes	No	Roaccutane	Yes	No
Aspirin/pain killers	Yes	No	Anti-coagulants	Yes	No
If 'Yes', please give details:					

Please list any medication you are taking (including supplements):

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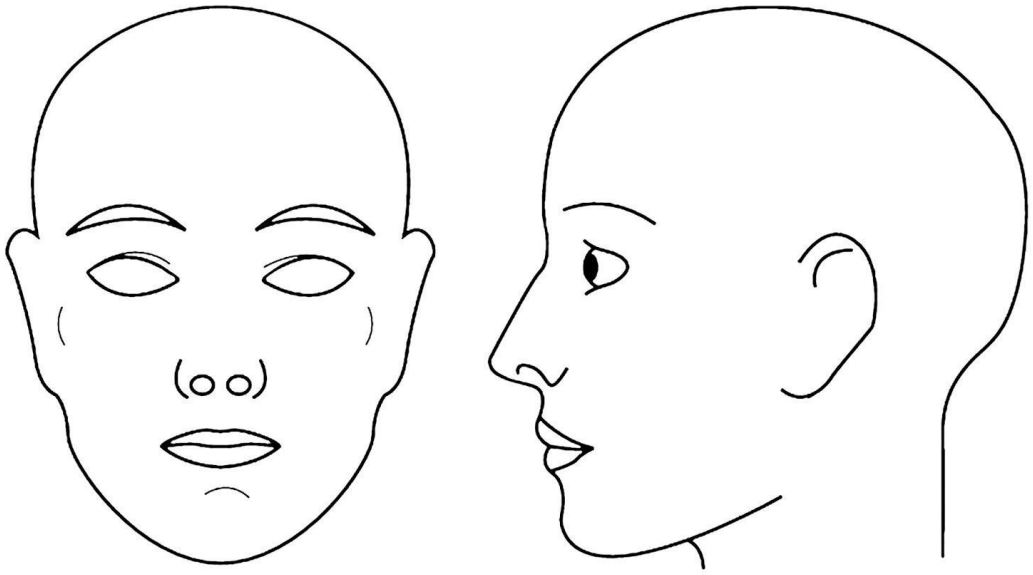
Are you allergic to any of the following?

Plasters	Yes	No	Stitches	Yes	No
Iodine	Yes	No	Local anaesthesia	Yes	No
Antibiotics	Yes	No	Beef/Pork	Yes	No
If 'Yes', please give details:					

If you have any questions about the above, please discuss these with your practitioner. If the answer is yes to any of the above, your practitioner may ask for further details. Treatment may not be possible if it is not considered in your own interest to proceed.

Your Anti-Wrinkle Concerns

Using the diagram below, please indicate the areas you are concerned about.



Patient name: _____ Signature: _____

Date: _____