DR JAS GILL
MEDICAL AESTHETICS

GENERAL CONSULTATION & COSMETIC PROCEDURE QUESTIONNAIRE

Name: _____ Ms/Miss/Mrs/Mr (delete as appropriate)

Address: _____

_____

Postcode: _____ Home Tel: _____

Mobile: _____ Email: _____

GP's Name, Address & Tel: _____

DOB _____

Do you smoke? YES/NO If "YES" how many a day _____

Do you drink alcohol? YES/NO If "YES" how many units a week? _____

Are you pregnant or breastfeeding? YES/NO

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

Laxatives/Vitamin E	YES/NO	St. John's Wort	YES/NO
Hormones/contraceptive pill	YES/NO	Gentamicin/Neomycin	YES/NO
Steroids/gold injections	YES/NO	Roaccutane/Accutane	YES/NO
Aspirin/pain killers	YES/NO	Anti-coagulants	YES/NO

If "YES" to any of the above, please give details or list ay other medication you are taking:

_____

Do you suffer from any allergies, particularly to hyaluronic acid or local anesthetics or lidocaine? YES/NO

Heart Disease/Angina	YES/NO	Thyroid Problems	YES/NO
Auto-Immune Disease	YES/NO	Arthritis	YES/NO
Asthma/Bronchitis	YES/NO	Convulsions	YES/NO
Facial Cold Sores	YES/NO	Depression	YES/NO
High/Low Blood Pressure	YES/NO	Diabetes	YES/NO
Stomach Ulcer/Colitis	YES/NO	Skin Disease (e.g. acne)	YES/NO
HIV/Hepatitis	YES/NO	Glaucoma/Cataract	YES/NO
Venereal Disease	YES/NO	Bell's/Facial Palsy	YES/NO
Phlebitis	YES/NO	Hypoglycemia	YES/NO
Myasthenia Gravis	YES/NO	Eaton Lambert Syndrome	YES/NO

If "YES" to any of the above, please give details or list any other conditions you may have:

_____

Have you ever been admitted to the Hospital? YES/NO

If “YES” please give details: _____

Have you had any previous surgery (non-cosmetic)? YES/NO

If “YES” please give details: _____

Have you previously had any cosmetic surgery, including eye/eyelid or facial surgery? YES/NO

If “YES” please give details: _____

Have you ever had Botulinum Toxin treatment before? YES/NO

If “YES” what was treated and when:_____

Did Botulinum Toxin treatment significantly improve your lines? YES/NO

Have you had Dermal Fillers before? YES/NO

If “YES” please give details and dates:_____ _____

Have you had any Sunbed treatment, Dermabrasion, Skin Peels or Laser Skin Resurfacing in the last 6 weeks? YES/NO

If “YES” please give details and dates:_____

Are you currently undergoing any Dental treatment? YES/NO

If “YES” please give details and dates:_____

Do you have any phobias that may affect treatment? (e.g. needles or blood) YES/NO

Are you particularly prone to fainting, bruising, keloid scarring or bleeding? YES/NO

Any other medical problems? _____

Patient Name: _____ Patient Signature: _____

If you answered “YES” to any of the questions, your Practitioner may ask you for more details to decide if you are suitable for treatment.

Dr. Jaskiran Gill	GDC 192112				

DOCTOR'S COPY

I have been informed of the nature & variety of products that are being used on my procedure today. I have been specifically informed about the risks and benefits of the treatments and especially (but not exhaustively):

- The risks and benefits of the treatment.
- The side effects around the area injected.
- The risk of infection.
- The risk of swelling and bruising.
- That there is always a small risk of asymmetry and the natural asymmetries cannot always be corrected.
- Risk of vessel blockage with filler and relevant presentation of symptoms.
- Risk of telangiectasia, granuloma, hemosiderin staining and nodules.
- All patients may need further chargeable sittings/treatments to get the desired result.
- Save as for emergency, we allow at least 3-4 weeks for lips & 6-8 weeks for other areas settling time before review.
- The risk of brow and/or lid ptosis, Diplopia, headache, muscle twitching on return of movement with Botulinum Toxin.
- My signature below indicates I fully understand the existence of a strict no-refund policy after administration of fillers and neurotoxins.

My questions have been answered satisfactorily.

I have answered the questions about my medical history to the best of my knowledge. Post procedure care has been explained well to me and I will follow the advice of the Doctor and Clinic.

I hereby voluntarily consent to the treatment. I hereby indicate my understanding that there is a strict no-refund policy after administration of treatment. I understand that no guarantee as to the final result of the treatment has been made to me.

Patient's Signature: _____ Date: _____

Print name (CAPITALS): _____

Physician's Signature: _____ Date: _____

PATIENT'S COPY

I have been informed of the nature & variety of products that are being used on my procedure today. I have been specifically informed about the risks and benefits of the treatments and especially (but not exhaustively):

- The risks and benefits of the treatment.
- The side effects around the area injected.
- The risk of infection.
- The risk of swelling and bruising.
- That there is always a small risk of asymmetry and the natural asymmetries cannot always be corrected.
- Risk of vessel blockage with filler and relevant presentation of symptoms.
- Risk of telangiectasia, granuloma, haemosiderin staining and nodules.
- All patients may need further chargeable sittings/treatments to get the desired result.
- Save as for emergency, we allow at least 3-4 weeks for lips & 6-8 weeks for other areas settling time before review.
- The risk of brow and/or lid ptosis, Diplopia, headache, muscle twitching on return of movement with Botulinum Toxin.
- My signature below indicates I fully understand the existence of a strict no-refund policy after administration of fillers and neurotoxins.

My questions have been answered satisfactorily.

I have answered the questions about my medical history to the best of my knowledge. Post procedure care has been explained well to me and I will follow the advice of the Doctor and Clinic.

I hereby voluntarily consent to the treatment. I hereby indicate my understanding that there is a strict no-refund policy after administration of treatment. I understand that no guarantee as to the final result of the treatment has been made to me.

Patient's Signature: _____ Date: _____

Print name (CAPITALS): _____

Physician's Signature: _____ Date: _____

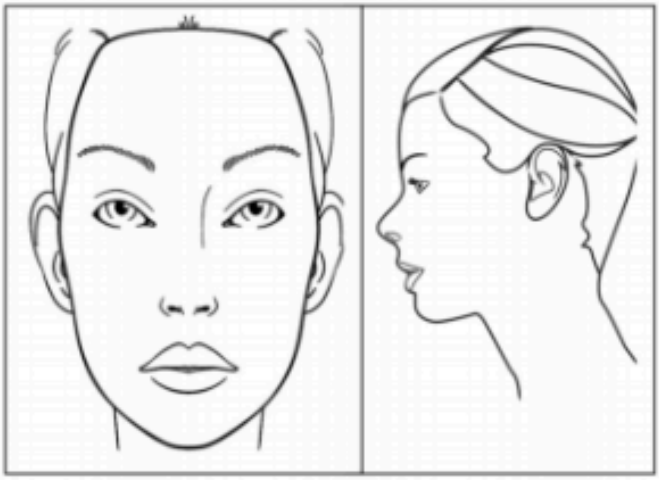
DR JAS GILL
MEDICAL AESTHETICS

PRODUCT 1	PRODUCT 2	PRODUCT 3	PRODUCT 4

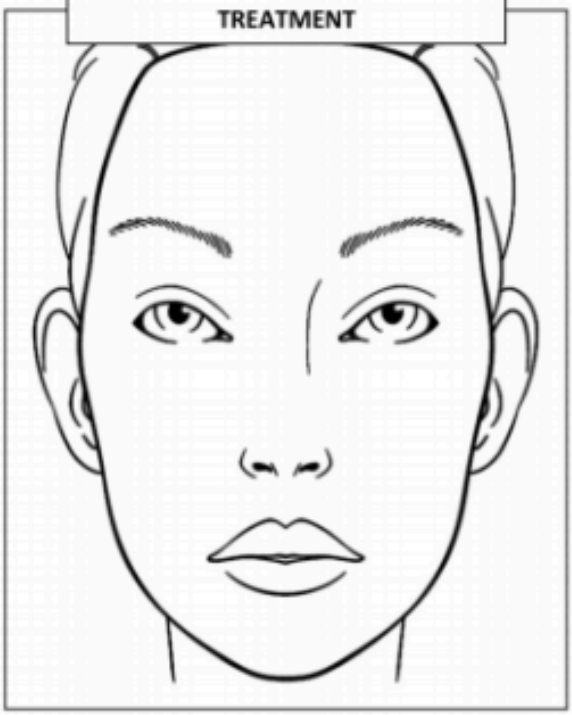
PRE-TREATMENT

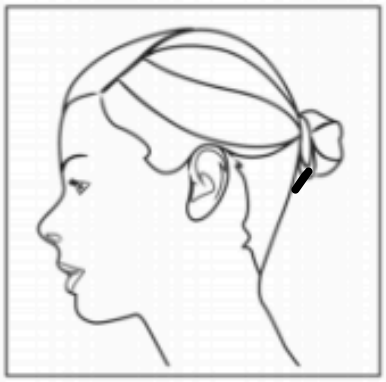
EXPECTATIONS:

PHI RATIO:



TREATMENT





Anaesthesia		
Septanest	Y	N
Lidocaine	Y	N

Pre - photo	Y	N
Post- photo	Y	N
Social Media	Y	N

Follow- up advice	Y
Aware of top-up policy	Y
Aware of associated risk	Y

Patient initials:

Signature: