Skye DENTAL

Dr. Jena Ward
BSc. BOralH (Dent. Sci.) GDipDent (Hons.)
Principle Dentist

Facial Injectable Treatment Medical History

For your safety and comfort, please answer the following questions accurately. Discuss anything you are unsure of with your Dentist - this information can have a serious impact on your treatment.

Name _____

Date of Birth _____

Address _____

Telephone _____

Private Email _____

Tick if you experience, or have experienced in the past, and provide details:

- ○ Allergies _____
- ○ Severe allergy, Anaphylaxis, gram positive bacterial infection or botulism
- ○ Herpes
- ○ Neuromuscular disorders – e.g. myasthenia gravis, eaton-lambert syndrome, multiple sclerosis
- ○ Skin cancer or other skin condition e.g. Psoriasis, Acne
- ○ Keloid / Hypertrophic scarring
- ○ Any other medical conditions/details:

_____

_____

Female patients – are you currently:

○ Breast-feeding ○ Pregnant

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Tick if you are taking any of the following or have taken them in the past 3 months and provide details:

- ○ Antibiotics – notably spectinomycin, gentamycin, clindamycin:_____
- ○ Non-Steroidal Anti-Inflammatory Drugs (NSAIDS): _____
- ○ Anti-coagulant therapy – e.g. Warfarin, Heparin, Aspirin: _____
- ○ Health supplements – e.g. Vitamin E, Omega-3 Fish Oils: _____
- ○ Corticosteroids, Muscle relaxants, sleeping tablets _____
- ○ Any other medications eg Roaccutane: _____

Have you previously received any of the following? If so, list the date, product, dosage and any problems

- ○ Botox / Dysport / Dermal Filler injections, Facial treatments – e.g. laser, micro-dermabrasion

_____
_____

Signature: _____

Date: _____

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