GALDERMA

EST. 1981

Restylane®

Treatment Record Form

MEDICAL HISTORY

PRECAUTIONS

Please tick ✔

	Yes	No
Is there any possibility that you are pregnant?	☐	☐
Are you breast feeding?	☐	☐
Have you recently been injected with anything in your face	☐	☐
If yes, where?		
Do you have any permanent implant(s) in your face?	☐	☐
Have you undergone laser treatment or received a skin peel in the past six weeks?	☐	☐
Do you suffer from facial herpes, cold sores or any active skin conditions, e.g. acne or psoriasis?	☐	☐
Do you have or have you ever had any form of skin cancer?	☐	☐
What are your expectations of the outcome of the treatment?		
.....		

CONSIDERATIONS

	Yes	No
Have you previously experienced hypersensitivity to hyaluronic acid, filler injections or Restylane products?	☐	☐
Have you ever experienced any hypersensitivity to lidocaine (a local anesthetic)?	☐	☐
Have you received oral isotretinoin or topical tretinoin treatments in the past 12 months?	☐	☐
Do you suffer from any known allergies?	☐	☐
If yes, please specify?		
Do you have a history of anaphylactic shock (severe allergic reactions resulting in difficulty breathing)?	☐	☐
Are you taking aspirin, steroids or anticoagulants?	☐	☐
If yes, please specify?		
Are you currently taking any other medication?	☐	☐
If yes, please specify?		
Do you suffer from any illnesses, e.g. angina, epilepsy, diabetes, HIV positive, hepatitis, auto immune disease (e.g. rheumatoid arthritis), depression, stress?	☐	☐
If yes, please specify?		
Have you recently undergone major surgery?	☐	☐
If yes, please specify?		
Are you currently undergoing dental surgery?	☐	☐
Do you suffer from fainting or low blood pressure?	☐	☐
Are you prone to keloids or hypertrophic scarring?	☐	☐
Do you have a fear of needles?	☐	☐
Are you prone to bruising?	☐	☐
Have you recently been exposed to the sun or sun beds?	☐	☐

IF THE ANSWER TO ANY OF THE ABOVE QUESTIONS IS "YES" THE PRACTITIONER MAY DECIDE THAT YOU ARE NOT SUITABLE FOR TREATMENT.

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PATIENT TREATMENT RECORD FORM

Last Name _____ First Name _____ Last 4 digits of NRIC _____

Gender _____ Date of Birth (dd-mm-yy) _____ Ethnicity _____

History/Previous Treatment _____ Clinic Name & Address _____

_____

_____

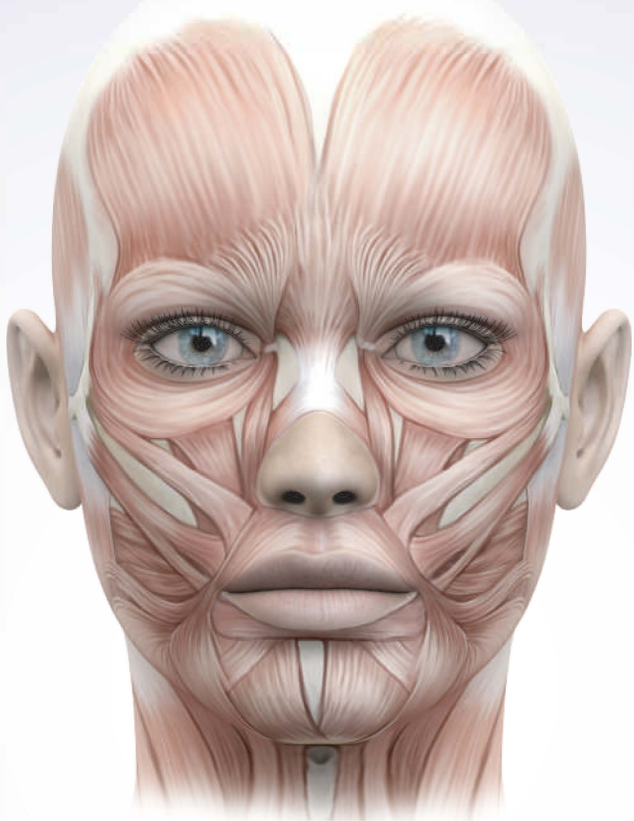
_____

TREATMENT SUMMARY

Treatment session #_____ (state number)

Amount Injected (mL)

Area Injected



Treatment notes: _____

_____

_____ Type of anaesthesia used: _____

Doctor's Name _____ Doctor's Signature _____ Date of treatment _____

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