PATIENT MEDICATION RECORD

Full Name: ____

Address: ____

Contact Number: ____

Email Address: ____

D.O.B.: ________________________ **Gender:** ______________

Practitioner: ____

Preparations Required: (please mark)

☐ __*Lidocaine + Tetracaine + Adrenaline Gel - 5g*__

☐ _*Lidocaine + Tetracaine Ointment – 5g*_________

Have you used a topical anaesthetic before: _________________________

If yes, state which one(s) and describe adverse reactions if any:

____

Have you had any other treatment or procedure done in the last TWO weeks: _____

If yes, Please list: ____

____

List ALL other Medications including topical creams/lotions and nutritional supplements (vitamins): ___________________________________

____

[Please indicate if using any specialised skin products**]**

List ALL Medical Conditions: ____________________________________

____

[Please indicate if Pregnant and/or Breastfeeding **]**

List any Food, Drug and/or Animal Allergies/Sensitivities: _______________

____

Collect from Pharmacy _________ **Clinic** _____________ **or Post** _____________

Signature: ____

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