Customer:

Email:

Phone:

Business Logo:

Completed: 17 Feb 2026 - 1:16 PM

Device Name: iPhone Mobile Website

IP Address: 92.21.212.243

Location: Camberley GB

Dermal Fillers Consultation & Consent Form

Dermal filler treatments are non-surgical aesthetic procedures designed to restore volume, enhance facial contours, and soften the appearance of lines and wrinkles. Using high-quality hyaluronic acid based fillers, these treatments help to support facial structure, improve symmetry, and create natural-looking, balanced results while maintaining individual facial harmony.Each dermal filler treatment is carefully tailored to your unique facial anatomy, concerns, and aesthetic goals. Treatments may be used to enhance areas such as the lips, cheeks, jawline, chin, nasolabial folds, marionette lines, and under-eye region. Results are visible immediately but not final, with continued improvement as swelling settles and the product integrates into the surrounding tissue.A thorough consultation is required before any dermal filler treatment to ensure safety, suitability, and optimal results. During this consultation, your medical history, current medications, allergies, previous aesthetic treatments, and lifestyle factors are carefully reviewed. A detailed facial assessment is performed to determine the appropriate product selection, placement technique, dosage, and treatment plan, as well as to identify any contraindications. Honest and accurate disclosure is essential to minimise risks, prevent complications, and create a safe, effective, personalised treatment plan aligned with your aesthetic goals.

1. Client Demographic Information

First Name: Fadumo

Last Name: Hussien

Address: 176

Marmot Road Cranford, Hounslow, Greater London, TW4 7PT

Email: Fatuma_Hussien@hotmail.co.uk

Phone: 07918495802

Gender: Female

Birth Date: 1 Jan 1997

Referred by: Groupon

Medical History & Skin Analysis

2. Are you currently under the care of a doctor or dermatologist?

No

3. If "Yes" please specify

Not Answered

4. Do you have any of the following conditions? Please answer truthfully, this ensures your treatment is safe and effective

Allergies (including lidocaine, hyaluronic acid, hyalunidase, latex), Active acne, hyperpigmentation, melasma, eczema, dermatitis cold sores (Herpes Simple), or skin infection, Current medications, supplements, or contraceptives (please list below)

5. If "Yes" to any of these including current medication" or "Other Medical Condition", please specify

Not allergic to anything regarding procedures but I have hayfever which sometimes acts up but not always. And hyperpigmentation on my face.

Medication:
60mg Elvanse
10mg Dexamfetamine Sulphate
20mg Citalopram
And multivitamins

6. Treatment Selection - Please select the treatment you’re booked for:

Tear trough

7. If "Other" please specify

Not Answered

8. When is the appointment scheduled?

18 Feb 2026

Cosmetic Treatment History

9. Please tick all that apply:

Not Answered

10. If "Yes", please specify area and date

Not Answered

CONTRAINDICATION CHECK

Please read carefully. Some conditions listed below are absolute contraindications, meaning treatment cannot be carried out under any circumstances. Others are relative contraindications, meaning treatment may still be possible but requires adjustment, additional precautions, or postponing the procedure.
Declaring these honestly is essential to protect your safety, prevent complications, and ensure the practitioner can choose the safest and most effective treatment approach.

11. Please tick any that apply:

History of keloid scarring or poor wound healing

---

12. Are you currently on any of the following?

Retinol / Vitamin A

Client's Consent (Mandatory)

Photographs are taken before and after treatment for medical documentation and client records.

13. Client Consent (Mandatory) Please confirm each statement:

I confirm that I have read, understood, and agree to follow the pre- and post-treatment information guide provided with this consultation and consent form., I confirm that the information I have provided is accurate, and I have disclosed all relevant medical history and allergies., I understand the general risks associated with aesthetic treatments, including bruising, swelling, asymmetry, infection, or temporary discomfort., I understand that results vary between individuals and that I may require further treatment for optimal or maintained results., I have had the opportunity to ask questions, and all my questions have been answered to my satisfaction., I understand that all aesthetic treatments provide temporary results and will naturally wear off over time, I consent to photographs being taken for my medical record, with optional separate consent for marketing below., I consent to the processing of my personal data in accordance with the clinic’s privacy policy and understand I can withdraw consent at any time.

14. Photo & Marketing Consent.

I consent to my photos being used anonymously for training or educational purposes., I do not consent to any use of my photos beyond my medical record.

15. Please sign and date to confirm that you have read, understood, and agree to the statements above.

X Customer's Signature

Feb 17, 2026 - 1:16 PM

16. Client's Name

Fadumo

X Employee's Signature

Feb 17, 2026 - 1:16 PM

18. Employee's Name

Jennifer

Practitioner Notes (For Internal Use Only)

19. For "Other", please specify area

Not Answered

Assessment:

Batch Number & Expiry Date:

Treatment Given / Units Used:

Post-Treatment Comments: