

## Medical History


Patient Name	:	Reshma Siya	Emirates ID	:	784-6478-3648736-8
File No	:	4	DOB	:	1995-05-21
Gender	:	Female	Doctor's Name	:	dermatology derma
			Date	:	2024-03-04

**Please complete the following questionnaire.**

	YES	NO	DETAILS
Are you currently pregnant, breast feeding or on fertility treatment? (if yes, please specify)	<input type="radio"/>	<input type="radio"/>	
Do you suffer from allergies? (if yes, please specify)	<input type="radio"/>	<input type="radio"/>	
Have you ever suffered from anaphylaxis as a result? (if yes, please specify)	<input type="radio"/>	<input type="radio"/>	
Are you currently receiving any medical treatment? (if yes, please specify)	<input type="radio"/>	<input type="radio"/>	
Have you ever had a non-surgical treatment before? (if yes, please specify)	<input type="radio"/>	<input type="radio"/>	
Have you ever had a reaction after receiving treatment? (if yes, please specify)	<input type="radio"/>	<input type="radio"/>	
Do you suffer from any illnesses? e.g. angina, epilepsy, diabetes, auto immune system, hepatitis, HIV positive..? (if yes, please specify)	<input type="radio"/>	<input type="radio"/>	
Do you suffer from any cutaneous infection or inflammatory problems? e.g. herpes/ acne. (if yes, please specify)	<input type="radio"/>	<input type="radio"/>	
Are you currently taking aspirin, steroids or anticoagulants (warfarin)? (if yes, please specify)	<input type="radio"/>	<input type="radio"/>	
Have you recently undergone surgery? (if yes, please specify)	<input type="radio"/>	<input type="radio"/>	
Do you suffer from high or low blood pressure? (if yes, please specify)	<input type="radio"/>	<input type="radio"/>	
Are you prone to bruising?	<input type="radio"/>	<input type="radio"/>	

### Procedure

xxx

Sign here, only if all of your questions have been answered to your satisfaction	
Patient	Doctor
	

<div>Patient Name Reshma Siya</div> <div>Date 2024-03-04</div>	<div>Doctor Name dermatology derma - Dermatology (0)</div> <div>Date 2024-03-04</div>
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