Please bill patient and
Call clinic for collection

Brisbane Compounding Pharmacy
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PATIENT QUESTIONAIRE & EVALUATION FORM
TOPICAL ANAESTHETIC

DETAILS OF PROCEDURE ***(Clinic Use Only)***

Clinic: Browskii Phone: 0432150456

Procedure: Brows/eyes/lips cosmetic tattoo (pls circle)

Medication required: 6/4/1 during

Area of topical anaesthetic application: Brows/eyes/lips (pls circle)

Amount of topical anaesthetic required: 10mls

PATIENT DETAILS

Name: _____

Address: _____

Phone: _____ Email: _____

HISTORY OF SKIN PRODUCTS & TOPICAL ANAESTHETIC USE

1. Have you used this medication before? Yes/No **(Please Circle)**
2. Have you ever had an adverse reaction to a topical anaesthetic (e.g. Emla, Xylocaine, LMX4)?
   Yes/No **(Please Circle)**
   If yes, please state name of medication and reaction: _____
   _____
3. In the past 2 weeks, have you used any products on the area to be treated which contain the following ingredients? **(Please Tick)**

□ Retinoids/ Vitamin A (e.g. Tretinoin, Retinol)	□ Hydroquinone, Azelaic acid, Kojic acid
□ Alpha Beta Hydroxy acids (e.g. Glycolic acid, Lactic acid, Salicylic acid)	□ Benzoyl peroxide or Adapalene (Differin)

   If yes, please provide details: _____
   _____
4. Have you ever had an adverse reaction to the above or other skin products?
   Yes/No **(Please Circle)**
   If yes, please provide details: _____
   _____

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HISTORY OF PRIOR PROCEDURES

1. Have you had this procedure before? Yes/No **(Please Circle)**
2. Have you had any of the following procedures in the past 2 weeks? **(Please Tick)**

□ Hair Removal (waxing, threading, etc)	□ Tanning Bed, Sun Exposure
□ Laser/IPL	□ Cosmetic Tattoo, Other Tattoos
□ Radio Frequency (RF)	□ Microdermabrasion
□ Chemical Peel	□ Plastic/Cosmetic Surgery
□ Other	

MEDICAL HISTORY

1. Do you have any allergies? Yes/No **(Please Circle)**
   If yes, please provide details: _____
   _____
2. Are you pregnant? Yes/No/Unsure **(Please Circle)**
3. Are you breast feeding? Yes/No **(Please Circle)**
4. Are you currently experiencing or have a history of any of the following? **(Please Tick)**

□ Pseudocholinesterase deficiency	□ Congenital or idiopathic Methaemoglobinemia
□ Skin cancer	□ Thrombosis/ Haemophilia/ Anaemia
□ Unusual moles, problematic moles (e.g. bleeding, itchy)	□ Cancer
□ Herpes (i.e. cold sores)	□ Diabetes
□ Skin conditions/ sensitivities (e.g. Rosacea, Impetigo, Eczema, Dermatitis)	□ Auto-immune disorders (e.g. Rheumatoid arthritis, Scleroderma, Lupus)
□ Shingles	□ HIV
□ Active skin infections	□ Epilepsy or seizure related condition
□ Hyper/hypo pigmentation after injury to skin	□ Cardiac conditions/Arrhythmias
□ Keloid or hypertrophic scarring	□ Asthma/ Respiratory conditions
□ Excessive bleeding from minor cuts	□ Liver Disease (e.g. Hepatitis)
□ Easily bruised	□ Glaucoma
□ Other	□ Thyroid Imbalance

If yes, please provide details: _____
_____

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MEDICATIONS

1. What medications and/or supplements are you currently taking (prescription and over the counter)?

Medication	Strength	Dose

I, _____ authorise and consent for my information to be disclosed to Brisbane Compounding Pharmacy, 1002/16 Hamilton Place, Bowen Hills, QLD, 4006. I understand that my information is strictly confidential and will only be shared between myself, the clinic and Brisbane Compounding Pharmacy.

I authorise either:

a) A representative of Browskii (Clinic) to collect my topical anaesthetic from Brisbane Compounding Pharmacy and store it appropriately according to the medication and pharmacy guidelines;

Or if required,

b) Brisbane Compounding Pharmacy to mail my topical anaesthetic to the above-mentioned clinic who will store it appropriately according to the medication and pharmacy guidelines.

I understand that this form is not a substitute for direct communication between myself, the clinician and the pharmacist. I acknowledge that I will be contacted by a pharmacist from Brisbane Compounding Pharmacy to determine the suitability, appropriate use and supply of the topical anaesthetic for my procedure. I will only use this medication the way it has been prescribed and will seek pharmacist assistance if necessary. If required, I give permission for my clinician to apply the topical anaesthetic as part of this procedure.

To the best of my knowledge, I have answered each question in this form completely and accurately.

Patient Name: _____

Signature: _____ Date: _____