

How would you describe your diet?

[Empty text box for diet description]

Do you smoke? If yes how many a day? Yes / No x

How many units of alcohol would you normally consume weekly?
..... units a week

Where did you hear about us?

[Empty text box for where heard about us]

I have read and understood the above questions and to the best of my knowledge the information I have given is correct.

Completed by: Self / Parent / Guardian (delete where applicable)

Signature:

Date:



New Patient Facial Aesthetics Welcome

Please note that all details entered on this form are and will remain confidential.

Personal details

Name:

Date of birth:

Address:

Home Tel:

Mobile:

E-mail:

Please tell us how you would prefer your reminders:

Telephone Mobile E-mail

Occupation:

GP's name:

GP's address:

Skin Care Habits and Medical History
(this will help us to give you the best advice possible)

Have you recently had any other facial treatment? YES / NO

If so, please give details:

Treatments?

.....

Where?

.....

When?

.....

Do you have any permanent implants? YES / NO

If yes – where?

.....

Have you had laser resurfacing or a skin peel in the past 6 weeks?

Have you had Roaccutane in the last 12 months?

Are you currently undergoing dental surgery?

Have you recently been exposed to the sun or sun beds?

What are your expectations or expected outcome of the treatment:

Do any of the following apply to you:

- | | | |
|---|--|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Allergies | <input type="checkbox"/> Anaphylactic shock |
| <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Breast-feeding | <input type="checkbox"/> Cold sores |
| <input type="checkbox"/> Facial wart | | |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Facial infections | <input type="checkbox"/> Hepatitis A |
| <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> HIV positive |
| <input type="checkbox"/> Hypertrophic scarring | <input type="checkbox"/> Keloid | |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Needle phobia | |
| <input type="checkbox"/> Nervousness / Depression | <input type="checkbox"/> Pregnant | <input type="checkbox"/> Skin Cancer |

Do you have a past medical history or family history of any of the following Neuromuscular transmission disorders:

- | | |
|---|---|
| <input type="checkbox"/> Myasthenia Gravis | <input type="checkbox"/> Lambert-Eaton Syndrome |
| <input type="checkbox"/> Motoneuron disease | <input type="checkbox"/> Multiple Sclerosis |

Have you ever been investigated for:

- | | | |
|---|--|--|
| <input type="checkbox"/> Drooping of the eyelid | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Muscle weakness |
|---|--|--|

Do you suffer from bleeding disorders or are you currently taking Anticoagulants (blood thinning drugs) e.g. aspirin, warfarin, or high doses of Vitamin E?

If so, please specify

Do you suffer from any illnesses e.g. angina, epilepsy, diabetes, HIV, Hepatitis, Auto-immune disease (e.g. rheumatoid arthritis), depression, stress?

If so, please specify.....

Have you taken any of the following in the last 3 days?

- | | |
|--|---|
| <input type="checkbox"/> Aminoglycoside antibiotics (Gentamicin, Neomycin, Netilmicin or Tobramycin) | |
| <input type="checkbox"/> Spectinomycin | <input type="checkbox"/> Penicillamine (anti-rheumatic) |
| <input type="checkbox"/> Calcium Channel blockers (Diltazem, Nifedipine or Verapamil) | |
| <input type="checkbox"/> Non-depolarising muscle relaxant | <input type="checkbox"/> Quinine (anti-malarial) |

Are you currently taking any other medication?