General Medical Consultation & Cosmetic Procedure Questionnaire

CONSULTING ROOM
Your Aesthetic Partner

Please fill form in block capitals – thank you

Full Name: DOB:

Address: Phone:

Email:

Postcode:

Please opt in to receive communication via: **Email** **SMS** **Mobile**

GP Details

Name: Address:

Tel:

Email Postcode:

How did you hear about us?

Do you smoke? **Yes** **No** **If yes, how many per day?**

Do you drink alcohol? **Yes** **No** **If yes, how many units per day?**

Are you pregnant or breastfeeding? **Yes** **No**

Are you currently taking, or have you ever taken any of the following medications?

Laxatives/Vitamin E **Yes** **No** **Hormones/contraceptive pil** **Yes** **No**

Steroid/Gold injections **Yes** **No** **Aspirin/Pain Killers** **Yes** **No**

Do you have a NUT ALLERGY? **Yes** **No** **Any other allergies?** **Yes** **No**

If 'YES' to allergies, please give details.

We would like to thank NATA (nataonline.co.uk) for their help in verifying that all the consent forms are complete.

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Do you suffer from any of the following?

Heart disease/Angina	**Yes** ☐	**No** ☐	**Thyroid problems**	**Yes** ☐	**No** ☐
Bells Facial Palsy	**Yes** ☐	**No** ☐	**Auto-immune disease**	**Yes** ☐	**No** ☐
Arthritis	**Yes** ☐	**No** ☐	**Phlebitis**	**Yes** ☐	**No** ☐
Asthma/Bronchitis	**Yes** ☐	**No** ☐	**Convulsions**	**Yes** ☐	**No** ☐
Diabetes	**Yes** ☐	**No** ☐	**Facial cold sores**	**Yes** ☐	**No** ☐
Depression	**Yes** ☐	**No** ☐	**High/low blood pressure**	**Yes** ☐	**No** ☐
HIV/Hepatitis	**Yes** ☐	**No** ☐	**Stomach ulcer/colitis**	**Yes** ☐	**No** ☐
Glaucoma/Cataract	**Yes** ☐	**No** ☐	**Skin disease (e.g. acne)**	**Yes** ☐	**No** ☐

Have you ever been admitted to a hospital? **Yes** ☐ **No** ☐

If 'YES', please give details:

Have you had any previous surgery (non-cosmetic)? **Yes** ☐ **No** ☐

Have you previously had any cosmetic surgery, including eye/eyelid or facial surgery? **Yes** ☐ **No** ☐

If 'YES', please give details:

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Have you had botulinum toxin treatment before? Yes ☐ No ☐

Did botulinum treatment significantly improve your lines? Yes ☐ No ☐

Have you had dermal fillers before? Yes ☐ No ☐

Have you had any sunbed treatment, dermabrasion, skin peels, or laser skin resurfacing in the last 6 weeks? Yes ☐ No ☐

If 'YES', please give details:

Are you currently undergoing any dental treatment? Yes ☐ No ☐

If 'YES', please give details:

Do you have any phobias that may affect treatment, e.g. needles or blood? Yes ☐ No ☐

If 'YES', please give details:

Are you particularly prone to fainting, bruising, keloid scarring or bleeding? Yes ☐ No ☐

Any other medical problems? Yes ☐ No ☐

If 'YES', please give details:

CLIENT DECLARATION

I confirm I have had the opportunity to ask questions, that these have been answered to my satisfaction, and that I freely choose to proceed with my treatment.

Client Signature: _____ Date: _____

PHOTOGRAPH CONSENT

I understand that photographs are necessary to document and track results, and that the clinic may ask to photograph the area(s) being treated, before and after the procedure. Such photographs will be done using the utmost discretion and will never be released without my full knowledge and expressed written consent

Consent given to publish photographs on our website/social media Yes ☐ No ☐

Client Signature: _____ Date: _____

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