

# Aesthetic Consultation 7/1/23

## PERSONAL DETAILS

NAME: \_\_\_\_\_ ADDRESS: \_\_\_\_\_  
POSTCODE: \_\_\_\_\_ DATE: \_\_\_\_\_ dd / mm / yyyy  
DATE OF BIRTH: \_\_\_\_\_ dd / mm / yyyy MOBILE: \_\_\_\_\_  
EMAIL: \_\_\_\_\_ PREFERRED CONTACT: \_\_\_\_\_

## CURRENT HEALTH

Do you have any current illnesses?

No  Yes

### DETAILS

Are you undergoing any investigations?

No  Yes

### DETAILS

Any recent, current or planned dental work?

No  Yes

### DETAILS

Do you take any medication?

No  Yes

### DETAILS

## MEDICATION HISTORY

---

Do you take, or have you recently taken?

- Hormone replacement
- Oral contraceptives
- Aspirin/NSAIDs
- St John's Wort
- Vitamin E
- Anticoagulants
- Roaccutane
- Antibiotics

Details

## ALLERGIES

---

Do you have any allergies?

- No  Yes

Do you have a history of severe allergic reaction or anaphylaxis?

- No  Yes

Do you have a history of severe allergic reaction or anaphylaxis?

- No  Yes

Have you had adverse reaction to aesthetic treatment in the past?

- No  Yes

Details

## MEDICAL HISTORY

---

Do you have a history of any of the following?

- |   |   |
|---|---|
| <input type="checkbox"/> Angina / Heart Disease | <input type="checkbox"/> Blood Clots            |
| <input type="checkbox"/> Auto-immune Disorder   | <input type="checkbox"/> Cold sores             |
| <input type="checkbox"/> Liver / Kidney Disease | <input type="checkbox"/> Low / High BP          |
| <input type="checkbox"/> Head-aches / Migraine  | <input type="checkbox"/> Thyroid Disorder       |
| <input type="checkbox"/> Myaesthesia Travis     | <input type="checkbox"/> Eaton-Lambert          |
| <input type="checkbox"/> Facial Palsy           | <input type="checkbox"/> HIV / Hepatitis        |
| <input type="checkbox"/> Keloid Scarring        | <input type="checkbox"/> Rheumatic Fever        |
| <input type="checkbox"/> Tuberculosis           | <input type="checkbox"/> Asthma / COPD          |
| <input type="checkbox"/> Diabetes               | <input type="checkbox"/> CVA                    |
| <input type="checkbox"/> Epilepsy               | <input type="checkbox"/> Skin Infection         |
| <input type="checkbox"/> Acne                   | <input type="checkbox"/> Eczema / psoriasis     |
| <input type="checkbox"/> Fainting               | <input type="checkbox"/> Convulsions / Epilepsy |
| <input type="checkbox"/> Cosmetic Surgery       | <input type="checkbox"/> Other                  |

**Details**

## LIFESTYLE

---

Do you take regular exercise?

- No  Yes

**Details**

Do you or have you ever smoked?

- No  Yes

**Details**

Do you drink alcohol?

- No  Yes

**Details**

Do you have a balanced diet?

- No  Yes

**Details**

Are you pregnant or trying to conceive?

- No  Yes

**Details**

Are you breast feeding?

- No  Yes

**Details**

Do you use sunbeds?

- No  Yes

**Details**

Do you have any planned vacations?

- No  Yes

**Details**

Do you use daily SPF?

- No  Yes

**Details**

What skincare products do you use?

- No  Yes

**Details**

Have you used retinol in last 2 months?

No  Yes

**Details**

Do you have any permanent or semi permanent make up?

No  Yes

**Details**

Are you needle phobic?

No  Yes

**Details**

Are you prone to bruising?

No  Yes

**Details**

Do you have any social events in the near future?

No  Yes

**Details**

Are you able to attend for review in 2 weeks?

No  Yes

**Details**

## AESTHETIC HISTORY

Please provided details of recent aesthetic treatments.

What

When

Where

**GOALS AND EXPECTATIONS**

What are your main areas of concern?

What are your expectations following treatment?

**ADDITIONAL NOTES**

**DECLARATION**

I confirm that the information I have given is correct.

NAME PRINT: \_\_\_\_\_

SIGNATURE

DATE: \_\_\_\_\_ dd / mm / yyyy

PRACTITIONER SIGNATURE