Cosmetic Surgery Intake

COSMETIC SURGERY INTAKE

This cosmetic surgery intake form helps your clinician understand your medical history, current health, and treatment goals before your consultation. Please complete all sections as accurately and honestly as possible, including details about previous surgeries, medical conditions, medications, allergies, and lifestyle factors such as smoking. If a question does not apply to you, mark it as "not applicable." Your responses are confidential and are used to ensure your consultation and treatment planning are safe, personalised, and appropriate for your needs. If you are unsure about any question, please provide your best answer and discuss it further with your clinician during your appointment.

Surname: _____ **Forename:** _____

Date of Birth: _____ dd / mm / yyyy

Sex at birth

◯ M ◯ F

If you do not identify with your sex at birth, please let us know how you now identify: **Mobile phone:** _____

Your Consultant: _____ **Date of Consultation:** _____ dd / mm / yyyy

Your Intended procedure: _____ **Date of procedure:** _____ dd / mm / yyyy

MEDICAL HISTORY QUESTIONNAIRE - OUTPATIENT

Main Skin Complaint:

Have you ever suffered from any of the following?

Heart Conditions

◯ No ◯ Yes

Comments / If you answer yes, please include the date

Angina (chest pain on exercise, at rest or at night)

◯ No ◯ Yes

Comments / If you answer yes, please include the date

Respiratory Conditions incl. Asthma

◯ No ◯ Yes

Comments / If you answer yes, please include the date

High blood pressure

◯ No ◯ Yes

Comments / If you answer yes, please include the date

Abnormal Bleeding Conditions

- ◯ No
- ◯ Yes

Comments / If you answer yes, please include the date

Hepatitis

- ◯ No
- ◯ Yes

Comments / If you answer yes, please include the date

Diabetes

- ◯ No
- ◯ Yes

If YES are you:

- ☐ Diet controlled
- ☐ Tablet controlled
- ☐ On insulin

Do you suffer from any other serious or significant diseases we should be aware of?

Comments / If you answer yes, please include the date

Deep vein thrombosis incl. blood clot in the lungs or any other vascular conditions?

- ◯ No
- ◯ Yes

Comments / If you answer yes, please include the date

Do you have sickle cell disease or trait?

- ◯ No
- ◯ Yes

Comments / If you answer yes, please include the date

Do you have any allergies?

- ◯ No
- ◯ Yes

If yes, please state:

Do you have a history of infections, such as MRSA?

◯ No ◯ Yes

If yes, please state

Do you have a history of mental disease?

◯ No ◯ Yes

Please include detail:

Do you have a history of any eating disorders?

◯ No ◯ Yes

Please Include detail

If you are female, are you/could you be pregnant?

◯ No ◯ Yes

If yes, what month of pregnancy?

Do you:

Take any regular medicines (tablets, patches, injections, inhalers; please include any herbal medications)?

◯ No ◯ Yes

If yes, please list in the next columns the name, the dose you take and how often you take them

Do you smoke?

◯ No ◯ Yes

If yes, how many per day?

Do you drink more than 21(men) 14(women) units of alcohol per week?

◯ No ◯ Yes

If yes, how many per week?

One unit of alcohol is about equal to half a pint of ordinary strength beer, lager or cider or 25ml of spirits; a small glass of wine is 1.5 units.

Have you had Diarrhoea and vomiting in the last 24 hrs?

◯ No ◯ Yes

Comment

Do you have any mobility, impairment or language issues that we should make adjustments for during your visit

◯ No ◯ Yes

If, so pleaes state mobility or imparimetnt issue and contact your patient advisor so they can arrange for adjustments to take place ahead of your visit

Is there anything else your consultant should know about?

◯ No ◯ Yes

Comment

Please let us know your height (denote metres or feet)

Please let us know your weight in kg

If you feel you would like further information about your procedure please contact your Surgeon directly

Do you consent to us sharing your medical record with your GP

◯ Yes ◯ No

CONSENT TO PHOTOGRAPHY

Consent to Photography – please tick the appropriate boxes. All images are anonymous and unidentifiable facially.

My Medical Practitioner may use pictures taken before and after my treatment for the following purposes:

Scientific / medical purposes

◯ No ◯ Yes

Media purposes

◯ No ◯ Yes

CONSENT TO SHARING INFORMATION

We participate in initiatives to monitor safety and quality, helping to ensure that patients are getting the best possible outcomes from their treatment and care. We are required to share records of the treatment that we provide with organisations including those appointed by government or by law, such as the Private Healthcare Information Network (PHIN). The records that we share may contain personal information about patients, including you. The organisations with whom we share these records, like us, apply the highest standards of confidentiality to personal information in accordance with data protection laws and the duty of confidentiality. Any information that is published is always in anonymised statistical form. This information will not be shared or analysed for any purpose other than those stated. Further information about how PHIN uses information, including its privacy policy, is available at www.phin.org.uk We will be happy to print a copy for you if you prefer.

Patient Name: _____

Patient Signature

Guardian Name: _____

Guardian Signature

Date: _____ dd / mm / yyyy