

Medical Questionnaire Form

Client ID: _____ Client Name: _____

Aesthetic Consultant Name: _____

Branch Address

- ☐ 200-Y Block Phase 4 DHA
- ☐ 49-E Maulana Shaukat Ali Road Johar Town
- ☐ Dr Ahmed's Signature Clinic 12 CCA Phase 4 DHA
- ☐ Bungalow # D-92/I Adjacent Lane Russian Embassy Block-4 Clifton
- ☐ Jahangir Multiplex beside Quaid-e-Azam International Hospital Main Peshawar Road Golra Mor
- ☐ Dr Humayun's Clinic House No 1B F8/3 Opposite Ali Medical Centre Main Kohistan Road

Presenting Concern

History of Presenting Concern

Do you have any current illnesses?

Do you have any of the following illnesses/complaints?

- ☐ Heart Disease
- ☐ Liver Disease
- ☐ Kidney Disease
- ☐ Skin Disease
- ☐ Blood Disorders
- ☐ None of the above

Other:

Any family history?

- ☐ Diabetes
- ☐ Hypertension
- ☐ Thyroid Disease
- ☐ Cardiovascular Disease
- ☐ Uric Acid
- ☐ Kidney Stones
- ☐ No significant family history

Other:

Please explain who the above pertains to?

- ☐ Father
- ☐ Mother
- ☐ Siblings
- ☐ Grandparents
- ☐ Not applicable

Other:

Have you had any surgeries?

Have you had any of the following invasive cosmetic procedures done?

- ☐ Botox
- ☐ Dermal Fillers
- ☐ Liposuction
- ☐ Cosmetic Surgery
- ☐ Chemical Peel
- ☐ Dermabrasion
- ☐ None of the above

Other:

Have you had any of the following non-invasive cosmetic procedures done?

- ☐ Cavitation
- ☐ Cryolipolysis
- ☐ Radiofrequency
- ☐ Shockwave
- ☐ HIFU
- ☐ Dermology
- ☐ None of the above

Other:

Are you currently using any dental implants?

☐ Yes ☐ No

Are you currently taking any medications?

Do you suffer from any allergies?

Are you currently pregnant?

☐ Yes ☐ No ☐ Maybe

Are you currently lactating?

☐ Yes ☐ No

Are you on Hormone Replacement Therapy?

☐ Yes ☐ No

Are you taking any Oral Contraceptives?

☐ Yes ☐ No

What is your current occupation?: _____

How would you rate your stress level (10 being the highest)?

012345678910

How many hours do you sleep per night?

- ☐ Less than 2 hours
- ☐ 2-5 hours
- ☐ 5-7 hours
- ☐ 7-9 hours
- ☐ More than 9 hours

How often do you exercise?

- ☐ Never
- ☐ Once in a blue moon
- ☐ A couple hours a week
- ☐ 1 hour every day
- ☐ 2-4 hours every day
- ☐ More than 4 hours every day

Do you smoke?

☐ Yes ☐ No

How often do you smoke?

- ☐ Less than 1 pack a week
- ☐ 1 pack a week
- ☐ 1 pack a day
- ☐ 2-3 packs a day
- ☐ More than 3 packs a day
- ☐ Not Applicable

Do you drink alcohol?

☐ Yes ☐ No

What is your relationship history?

- ☐ Married
☐ Divorced
☐ Widow
☐ Single
☐ Prefer not to answer

How many children do you have (if any)?:

How old is your youngest child?: _____

Recommended Treatment(s)

- | | |
|---|---|
| ☐ 3D - Bespoke Non-Surgical Fat Removal | ☐ 3D - Bespoke Skin Tightening |
| ☐ 3D - Bespoke Cellulite Removal | ☐ Body HIFU |
| ☐ 3D - Fat Freeze - Targeted Fat Removal | ☐ 3D - Duo Fat Freeze - Targeted Fat Removal |
| ☐ Signature Body Treatments - 3D 5 Point Lower Lift - Celebrity Favorite | ☐ 3D - Bum Lift |
| ☐ Thigh Gap Treatment | ☐ Bingo Wings Treatment |
| ☐ 4 Manboob | ☐ 3D Prescriptive Anti - Aging Facial |
| ☐ 3D Prescriptive Pigmentation Facial | ☐ Signature Facial Treatments |
| ☐ 3D - RF Dermalrolling | ☐ 3D - Skin Sculpting and Tightening |
| ☐ 3D - Chin Freeze | ☐ 3D Non-Surgical Eye Lift |

Treatment Option(s) selected

Total number of sessions: _____ Recommended date for first session: _____ dd / mm / yyyy

Total treatment price: _____

Client's expectations of the Treatment(s)

Client's questions and concerns

Consultant's Remarks