Aesthetic Consultation Form - Good Place Clinic & Spa

MEDICAL HISTORY FORM ADVANCED AESTHETIC TREATMENTS

Patient name: _____ **Date of birth:** _____ dd / mm / yyyy

Address: _____ **Postcode:** _____

Email: _____ **Phone number:** _____

Emergency contact: _____ **Phone:** _____

Relationship: _____

CURRENT HEALTH

Do you have any current illnesses?

◯ No ◯ Yes

If yes to any of the above please give details:

Are you undergoing any investigations?

◯ No ◯ Yes

If yes to any of the above please give details:

Any recent, current or planned dental work?

◯ No ◯ Yes

If yes to any of the above please give details:

Do you take any medication?

◯ No ◯ Yes

If yes to any of the above please give details:

MEDICATION HISTORY

Do you take, or have you recently taken?

- [ ] Hormone replacement
- [ ] Oral contraceptives
- [ ] Aspirin/NSAIDs
- [ ] St John's Wort
- [ ] Vitamin E
- [ ] Antico-agulants
- [ ] Roaccutane
- [ ] Antibiotics

If yes to any of the above please give details:

ALLERGIES

Do you have any allergies?

○ 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

If yes to any of the above please give details:

MEDICAL HISTORY

Do you have a history of any of the following?

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

If yes to any of the above please give details:

LIFESTYLE

Are you pregnant or trying to conceive?

◯ No ◯ Yes

If yes to any of the above please give details:

Are you breast feeding?

◯ No ◯ Yes

If yes to any of the above please give details:

Have you used retinol in last 2 months?

◯ No ◯ Yes

Are you needle phobic?

◯ No ◯ Yes

Are you prone to bruising?

◯ No ◯ Yes

AESTHETIC HISTORY

Please provide 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

ADDITIONAL NOTES

DECLARATION

I confirm that the information I have given is correct.

NAME PRINT: _____

Patient signature:

DATE: _____ dd / mm / yyyy