Medical Consultation Form

The purpose of this consultation form is to assess your suitability for treatment and patient safety. This information will be securely stored for ten years and not shared with any third party.

Title: Mr / Mrs / Miss / Ms / Other	M / F
Full Name:	
Address:	
	Post Code:
Home Tel no:	
Work Tel no:	
Mobile Tel no:	
Email address:	
Occupation:	DOB:

GP name:
Address:
Post Code:
Tel no:

PREVIOUS COSMETIC TREATMENT:

Have you had any previous cosmetic surgery (minor or major) under local or general anaesthetic? YES/NO
If yes please give details of the type of surgery and dates performed:
_____
_____

Are you awaiting any specialist appointment? (including dental) YES/NO
If yes please give details:

Have you had any of the following? Botox, Dermal Fillers (temporary or permanent)? YES/NO
If yes please give details with dates:
Botox; _____
Dermal Fillers; _____
Eye/Eyelid or Facial surgery; _____

Medical History **Date:…….**

Do you suffer from any of the following?

	No	Yes	If Yes, please clarify
General health problems	☐	☐	
Phobias e.g. needles, blood	☐	☐	
Severe bruising, fainting or scarring	☐	☐	
Medication/topical creams including asprin and herbal Remedies both current and within the last 6 months	☐	☐	
Allergy conditions (including latex, elastoplast, non surgical products, Anaphylactic shock) If yes please clarify.	☐	☐	
Have you ever had a reaction to a local/ dental Anaesthetic	☐	☐	
Photosensitivity	☐	☐	
Auto Immune disease/Connective tissue disorders	☐	☐	
Epilepsy	☐	☐	
Arthritis	☐	☐	
Thrombosis, bleeding disorders, bruising	☐	☐	
Active cardiac problems / Heart problems (including do you have a pace maker?)	☐	☐	
Diabetes, asthma, liver or kidney disease	☐	☐	
Depression	☐	☐	
Convulsions	☐	☐	
High/Low blood pressure	☐	☐	
Stomach ulcers/Colitis	☐	☐	
HIV/Hepatitis	☐	☐	
Cold sores	☐	☐	
Do you have a cochlear implant	☐	☐	
Skin conditions or pigmentation problems, including a history of keloid, hypertrophic scarring or malignant lesions	☐	☐	
Skin Disease e.g. Acne	☐	☐	
Have you recently used a sunbed, tanning products or recently had Dermabrasion, skin peels, skin resurfacing	☐	☐	
Are you pregnant or breast feeding	☐	☐	
Do you smoke, if yes how many per day	☐	☐	
Do you drink alcohol, if yes how many units per day	☐	☐	
Previous cosmetic treatments or surgery	☐	☐	See previous page

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

	No	Yes	Past or Present
Laxatives/Vitamin E	☐	☐	
Hormones/Birth control pill	☐	☐	
Steroids/Gold injections	☐	☐	
Asprin/Pain killers	☐	☐	
St Johns Wort	☐	☐	
Gentamicin/Neomicin	☐	☐	
Roaccutane	☐	☐	
Anti Coagulants	☐	☐	

Please list below all your current medication

Have you been admitted to hospital?
If yes please give details: _____

☐ I confirm the health history is accurate and complete. I understand that withholding any medical information may be detrimental to my health and safety during the procedure which the practitioner agrees to undertake. If there is any change in my medical history, it is my responsibility to advise the Doctor / Practitioner

☐ In accordance with the requirements of the Data Protection Act I consent to the disclosure of sensitive personal data by Facethetics Training or relevant Doctors, Nurses and Pharmacies etc for the purpose of discussing procedures concerning myself.

☐ I consent to receiving email and SMS updates from Facethetics Training. I understand that my details will not be shared with any third parties.

Signed by Patient _____ Date _____

Signed by Practitioner _____ Date _____