consultation form

Client name

_____

Date of birth

_____/_____/_____

Address

_____
_____
_____

Postcode

_____

Home phone

_____

Mobile

_____

Email address

_____

Doctor's name and address

_____
_____
_____

Previous treatments and reason for treatment

_____
_____
_____
_____
_____
_____
_____
_____

Medical history

If any are marked yes, please go into more detail in the space under the condition.

Heart conditions/pacemaker yes/no

Severe circulatory disorders/DVT yes /no

Diabetes yes/no

Skin disorders yes/no

Kidney problems yes/no

Swelling/oedema yes/no

Haemophilia yes/no

Cancer yes/no

Limitation of body movement/arthritis yes/no

Prone to keloid scarring yes/no

Hormone imbalance yes/no

Stroke yes/no

Claustrophobia yes/no

Hepatitis yes/no

Metal plates/pins/piercings yes/no

Recent scar tissue/surgery yes/no

Respiratory problems yes/no

Allergies yes/no

Are you pregnant yes/no

High/low blood pressure yes/no

Epilepsy yes/no

Operations within 6 months yes/no

Any other medical conditions/ailments yes/no
Please specify

_____

_____

Medication/treatments / additional information

Steroids yes/no

Retinol or Roaccutane yes/no

Other medication yes/no

Products containing fruit acids yes/no

Ultra violet exposure yes/no

Microdermabrasion yes/no

Laser/IPL yes/no

Any other medications yes/no
Please specify

_____

_____

Declaration

I declare that the above information I have given concerning my health is correct

Signature_____ Date_____/_____/_____