THE CONSULTANT CLINIC

GENERAL CONSULTATION & COSMETIC PROCEDURE QUESTIONNAIRE

Name: _____ Ms/Miss/Mrs/Mr

Address: _____

_____

Postcode: _____ Home Tel: _____

Mobile: _____ Email: _____

GP's Name, Address & Tel: _____

DOB _____

Do you smoke? ○ YES/NO ● If "YES" how many a day _____

Do you drink alcohol? ○ YES/NO ● If "YES" how many units a week? _____

Are you pregnant or breastfeeding? ○ YES/NO ●

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

Laxatives/Vitamin E	○ YES/NO ●	St. John's Wort	○ YES/NO ●
Hormones/contraceptive pill	○ YES/NO ●	Gentamicin/Neomycin	○ YES/NO ●
Steroids/gold injections	○ YES/NO ●	Roaccutane/Accutane	○ YES/NO ●
Aspirin/pain killers	○ YES/NO ●	Anti-coagulants	○ YES/NO ●

If "YES" to any of the above, please give details or list ay other medication you are taking:

_____

Do you suffer from any allergies, particularly to hyaluronic acid or local anesthetics or lidocaine? ○ YES/NO ●

Heart Disease/Angina	○ YES/NO ●	Thyroid Problems	○ YES/NO ●
Auto-Immune Disease	○ YES/NO ●	Arthritis	○ YES/NO ●
Asthma/Bronchitis	○ YES/NO ●	Convulsions	○ YES/NO ●
Facial Cold Sores	○ YES/NO ●	Depression	○ YES/NO ●
High/Low Blood Pressure	○ YES/NO ●	Diabetes	○ YES/NO ●
Stomach Ulcer/Colitis	○ YES/NO ●	Skin Disease (e.g. acne)	○ YES/NO ●
HIV/Hepatitis	○ YES/NO ●	Glaucoma/Cataract	○ YES/NO ●
Venereal Disease	○ YES/NO ●	Bell's/Facial Palsy	○ YES/NO ●
Phlebitis	○ YES/NO ●	Hypoglycemia	○ YES/NO ●
Myasthenia Gravis	○ YES/NO ●	Eaton Lambert Syndrome	○ YES/NO ●

If "YES" to any of the above, please give details or list any other conditions you may have:

_____

THE CONSULTANT CLINIC

Have you ever been admitted to the Hospital? ◯ YES/NO ◉

If "YES" please give details:_____

Have you had any previous surgery (non-cosmetic)? ◯ YES/NO ◉

If "YES" please give details:_____

Have you previously had any cosmetic surgery, including eye/eyelid or facial surgery? ◯ YES/NO ◉

If "YES" please give details:_____

Have you ever had Botulinum Toxin treatment before? ◯ YES/NO ◉

If "YES" what was treated and when:_____

Did Botulinum Toxin treatment significantly improve your lines? ◯ YES/NO ◉

Have you had Dermal Fillers before? ◯ YES/NO ◉

If "YES" please give details and dates:_____

Have you had any Sunbed treatment, Dermabrasion, Skin Peels or Laser Skin Resurfacing in the last 6 weeks? ◯ YES/NO ◉

If "YES" please give details and dates:_____

Are you currently undergoing any Dental treatment? ◯ YES/NO ◉

If "YES" please give details and dates:_____

Do you have any phobias that may affect treatment? (e.g. needles or blood) ◯ YES/NO ◉

Are you particularly prone to fainting, bruising, keloid scarring or bleeding? ◯ YES/NO ◉

Any other medical problems? _____

Patient Name: _____ Patient Signature: _____

Date: _____

If you answered "YES" to any of the questions, your Practitioner may ask you for more details to decide if you are suitable for treatment.