Have you attended our practice previously? If you have attended our practice previously, then there is no need to complete all the personal details. We only require your first and last name.

TITLE: MR / MRS / MS / DR / OTHER:_____________________________

FIRST NAME: ____MIDDLE INITIAL:_______

LAST NAME:____

DATE OF BIRTH: _____/_____/_____

ADDRESS: ____

____POSTCODE:____________

PHONE: (H) _____________________________ W):________________________________

MOBILE: ____

EMAIL: ____

What type of problem are you consulting for: Please tick.

□ Hair Removal □ Sun spots □Wrinkles □ Enlarged blood vessels □ Flushing of the skin □ Large pores □ Acne □ Skin rejuvenation □ Freckles □ Rosacea □ Brown Lesions

Are your present skin problems getting more pronounced? □ Yes □ No

Have you ever been treated for this problem? □ Yes □ No

If yes, when? ___________________ By what method? ______________________________________

Are you currently taking medication for your skin problem? □ Yes □ No

If yes, which medication?____

Are you pregnant, nursing, or planning a pregnancy soon? □ Yes □No

Do you have a history of bad scarring or discolored scars? □ Yes □ No

Do you have a history of: □ Heart disease □ Cold sores/ fever blisters □ Bruising □ Diabetes □ Bleeding disorders □ Dark spots after pregnancy □ Skin cancer, or suspicious moles □Skin injury(red/brown)

Have you had any allergic reactions to topical anesthesia? □ Yes □ No

Do you have any skin related allergies? □ Yes □ No If yes, please specify

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Do you have any allergies to medication? □Yes □ No If yes, please specify

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Do you take any medication? □Yes □ No If yes, please specify

What medication do you take?____

____

Are you taking any herbal preparations? (St. John's Wort, etc.) □ Yes □ No If yes, list

____

What is your daily consumption of alcohol? ___________________________________

Do you wear contact lenses? □Yes □ No

Have you had cold sores or fever blisters? □ Yes □ No

When were you last exposed to the sun (or a tanning booth)? _________________

Do you use bronzers, self tanners or chemical sun tanning lotions? ______________________________

Are you planning significant sun exposure in the next 2 weeks? □Yes □No

Have you ever had laser treatments or chemical peels? □Yes □No

What other skin care treatments have you had in the past? _______________________

Have you ever had treatments for pigmented lesions? □ Yes □ No Prior treatment (if any)

Have you had any surgical or medical treatments on the area we will be treating?

Patient Signature ____________________________________ Date ______________