FACECLINIC LONDON

Initial assessment and consultation form

Name:_____ **D.O.B**: _____

Address:_____

E-mail:_____

□ I consent to receive email confirmations and reminders about appointments I book with Face Clinic London

□ I consent to receive marketing emails from Face Clinic London about other relevant treatments, special offers and products

Contact Phone Number (mobile preferred):_____

Next of Kin Details (For use only in case of emergency):_____

Name and Relationship to Client:_____

Contact Phone Number:_____

WHERE DID YOU HEAR ABOUT US?

_____

WHAT TREATMENTS HAVE YOU HAD BEFORE & TO WHICH AREAS OF YOUR FACE/BODY?

_____

WERE YOU HAPPY WITH THE RESULTS?

_____

WHAT ARE YOU EXPECTATIONS FROM THE CONSULTATION TODAY?

_____

DO YOU HAVE ANY PARTICULAR CONCERNS?

_____

WHAT TREATMENTS ARE YOU INTERESTED IN?

▭ **Wrinkle Treatment ►** Where? _____

▭ **Dermal Filler ►** Where? _____

▭ **Sweating Treatment ►** Where? _____

▭ **PRP Therapy ►** Where? _____

▭ **Cryotherapy ►** Where? _____

Dr. Anita Kapoor MBBS, MRCGP, DRCOG, DFFP, Dip Clin Derm GMC No. 3276509 MPS Registered
Dr. Mark Lister MBchB, BSC, DFSRH, DRCOG, MRCGP GMC No. 6146735 MDU Registered

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Name DOB Date

Medical Details

In order for us to ensure that it is safe to proceed with any particular treatment, it is important that our practitioner has a clear understanding of your current and past medical history.

Please indicate if any of the following apply to you.

Condition	Please Circle	Detail
Pregnancy/Breastfeeding or trying to conceive	Yes / No	
Thrombosis/Bruising/Blood Disorders	Yes / No	
Facial Cold Sores	Yes / No	
Heart Disease/Angina	Yes / No	
Autoimmune disease	Yes / No	
Thyroid Problems	Yes / No	
Arthritis	Yes / No	
Seizures	Yes / No	
Asthma/Bronchitis	Yes / No	
High or Low Blood Pressure	Yes / No	
Stomach ulcers/colitis	Yes / No	
Liver disease	Yes / No	
Diabetes	Yes / No	
Eye disease	Yes / No	
Mental health problems including depression/anxiety	Yes / No	
Skin problems including abnormal scarring	Yes / No	

Receiving medical treatment for any other condition (please detail):

Please list all your current medications:

Please list any allergies you have:

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Name DOB Date

Aesthetic Medicine and Treatment Assessment

Reasons for wanting treatment

Which aspects of your face concerns you? _____

How does this make you feel? (Please tick all that apply)

Concerned about ageing	□
Anxious or depressed	□
Lacking in self confidence or self esteem	□
It interferes with social life/job/family	□
It makes me unhappy	□
I adapt my behaviour (e.g. covering your mouth when you speak, wearing a hairstyle to cover your face)	□
I feel tense and have trouble relaxing	□
I avoid certain social situations because of how I feel	□
I spend a lot of time thinking about my concern	□
It makes me sweat and/or have hot flushes	□
I avoid looking in the mirror	□

How would you like to feel after treatment? (Please tick all that apply)

I want to feel happier in myself	□
I want to feel confident in social or work situations	□
I want to look and feel more relaxed	□
I want to be able to concentrate on my life and not on how I look	□

Other (please detail)

_____
_____
_____
_____
_____

□ I understand information about me will be treated as confidential and access to it restricted in accordance with General Data Protection Regulation unless specific permissions given.

□ I am aware that I may withdraw my consent at any time, and that all automatic communications from Face Clinic London contain an unsubscribe link

□ I consent to before and after photographs of myself to be taken by Face Clinic London for treatment record. Photographs will be stored securely by Face Clinic London and viewed only by Face Clinic London staff. I understand that no fee is payable to me or any other person in respect of the material either now or at any time in the future.

Patients Signature: _____ Date: _____

Doctors Signature: _____ Date: _____

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