Medical /consultation form for Plasma treatments

Please take the time to read this form carefully and to understand any accompanying information if applicable.

Please answer all the questions below to the best of your knowledge.

Full name:
D.O.B:
Address:
Mobile telephone number:
Home telephone number:
Email address:
Doctors name:
Doctors address:
Doctors telephone number:

Please tick the appropriate box	**Yes**	**No**
Do you have any current or chronic medical illnesses i should be aware of? If yes, please state below (for example- thyroid, heart conditions, cancer, cancer within your family, epilepsy, diabetes)		
Do you suffer with diabetes? If yes, is it controlled?		
Have you had any major or minor surgery? If yes, please state below:		
Are you taking any medication, herbal or natural supplements, topical lotions, or creams on a daily basis? (for example- antibiotics, hormones (hrt), retin-a, glycolic lactic acid, contraception) if yes, please state below:		
Are you taking blood thinners such as warfarin?		
Do you have or suffer with cold sores?		
Do you have hiv?		
Have you had any semi-permanent makeup, implants, or tattoos?		
Are you pregnant or breastfeeding?		
Do you get nervous or twitchy?		
Do you suffer with claustrophobia?		

Do you suffer with active acne?		
Do you suffer rosacea?	**Yes**	**No**
Have you ever taken Roaccutane or Accutane? If yes, please state when:		
Do you have any active skin infections such as impetigo?		
Do you have any raised lesions or scarring? If yes, please state where:		
Do you bruise easily?		
Do you bleed easily?		
Does your skin feel tight, dry or even flake?		
Do you have a pacemaker or ecg/blood monitoring system?		
Do you have any implanted electrical devices?		
Do you have any metal implants in the treatment area?		
Do you have any skin problems?		
Do you have any oncological diseases?		
Do you suffer with epilepsy?		
Do you have a pacemaker?		
Do you suffer with varicose veins?		
Have you ever experienced pigmentation disorders such as melasma, chloasma or port wine stain?		
Do you have any vascular lesions such as veins or blood spots? If yes, please state where:		
Do you have any broken capillaries or thread veins? If yes, please state where:		
Do you blush easily?		
Do you suffer with heat rash?		
Do you suffer with eczema or dermatitis? If yes, please state where:		
Have you had any sun exposure in the last 4 weeks? If yes, did you burn?		
Do you consent for the therapist to use before and after photos of your treatment for advertising purposes? Including social media posts		

Emergency contact name & mobile number. ……

Please do not book your appointment 2 weeks prior and 3 weeks post covid19 vaccine.

Do you, or anyone in your household? Have symptoms of covid-19? Y/n?

Please do not book or attend your appointment if the answer is yes.

Please bring photo id and proof of address for purpose of track & trace.

Please tick here if you would like to be signed up to our email and receive exclusive offers? Yes / no

Please change your usual creams to organic aloe vera gel 5 days before treatment.

I …… certify that all the information I have provided is true and I have answered all the questions above to the best of my knowledge. I am aware that it is solely my responsibility to inform the therapist of any changes in the information I have given.

Client name:

Client signature:

Date:

Therapist name:

Therapist signature:

Date:

Patient ongoing consent form

	Yes	No
Full name confirmed		
D.O.B confirmed		
Address confirmed		
Any change in medical circumstances		
Any new medication/supplements		
Sun exposure in the last 4 weeks		
Pregnancy		
Have you even experienced and swelling, bruising, lumps, or bumps from treatment		
I consent to the treatment being carried out		
Client signature: **date:**		
Practitioner signature: **date:**		

	Yes	No
Full name confirmed		
D.O.B confirmed		
Address confirmed		
Any change in medical circumstances		
Any new medication/supplements		
Sun exposure in the last 4 weeks		
Pregnancy		
Have you even experienced and swelling, bruising, lumps, or bumps from treatment		
I consent to the treatment being carried out		
Client signature **date:**		
Practitioner signature **date:**		

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Sun exposure in the last 4 weeks		
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