Initial contact Questionnaire

Name: _____ Title – Mr / Mrs / Miss

Address: _____

County: _____ Postcode: _____ Home Tel: _____

Work Tel: _____ Mobile: _____ e-mail: _____

Date of Birth: _____ Age at consultation: _____

What is your occupation? _____

How did you hear about us? _____

Do you smoke? ❑ Yes ❑ No How many per day? _____ If 'no' – have you ever smoked? ❑ Yes ❑ No

What is your current weight? _____ What is your height? _____

Are you trying to lose weight? ❑ Yes ❑ No If 'yes' how much _____

Is your diet: ❑ Normal ❑ Vegetarian ❑ Vegan ❑ Gluten Free (please delete) Other: _____

Do you take regular exercise? ❑ Yes ❑ No Type of exercise: _____ Frequency: _____

Do you drink alcohol? ❑ Yes ❑ No approx How many units per week?: _____

Are you currently pregnant or breast-feeding? _____

ARE YOU CURRENTLY TAKING OR HAVE YOU EVER TAKEN ANY OF THE FOLLOWING MEDICATIONS:

Laxatives/Vitamin E	❑ Yes ❑ No	St Johns Wort	❑ Yes ❑ No
Hormones/Birth Control Pill	❑ Yes ❑ No	Gentamicin/Neomicin	❑ Yes ❑ No
Steroids/Gold Injections	❑ Yes ❑ No	Roaccutane	❑ Yes ❑ No
Aspirin/Pain killers	❑ Yes ❑ No	Anti Coagulants	❑ Yes ❑ No

If yes - please give details:

PLEASE LIST BELOW ALL YOUR CURRENT MEDICATION

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING:

Elastoplast	❑ Yes ❑ No	Stitches	❑ Yes ❑ No
Iodine	❑ Yes ❑ No	Local Anaesthesia	❑ Yes ❑ No
Antibiotics	❑ Yes ❑ No	Beef / Pork	❑ Yes ❑ No

If yes - please give details:

Are you currently undergoing desensitisation treatment? Yes/No If Yes, for which allergen? _____

HAVE YOU SUFFERED FROM ANY OF THE FOLLOWING CONDITIONS:

Condition		Condition	
Heart Disease/Angina	❑ Yes ❑ No	Thyroid Problems	❑ Yes ❑ No
Auto Immune Disease	❑ Yes ❑ No	Arthritis	❑ Yes ❑ No
Asthma / Bronchitis	❑ Yes ❑ No	Convulsions	❑ Yes ❑ No
Cold Sores on the Face	❑ 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	Hypoglycaemia	❑ Yes ❑ No
Myasthenia Gravis Eaton-Lambert Syndrome	❑ Yes ❑ No		

Have you had any previous general surgery? ❑ Yes ❑ No

If 'yes' please give details: _____

Have you been admitted to hospital? ❑ Yes ❑ No

If 'yes' please give details: _____

COSMETIC PROCEDURES

Have you had any previous cosmetic surgery (minor or major) under local or general anaesthetic? ❑ Yes ❑ No

If 'yes', please give details of the type of surgery and dates performed: _____

Have you had any of the following? Botox, Dermal Fillers (temporary or permanent)? ❑ Yes ❑ No

If 'yes', please give details with dates: Botox: _____

Dermal Fillers: _____

Eye/Eyelid or Facial Surgery: _____

Do you have any phobias? e.g. blood, needles. ❑ Yes ❑ No If 'yes', please give details: _____

Do you have a history of Anaphylatic Shock (severe allergic reaction)? ❑ Yes ❑ No

Are you currently undergoing any Dental Treatment? ❑ Yes ❑ No

Are you prone to fainting, bruising or scarring? ❑ Yes ❑ No

Are you prone to bleed easily or suffer from any bleeding disorders? ❑ Yes ❑ No

Have you recently been exposed to Sun Beds, had Dermabrasion, Skin Peels, or Laser Resurfacing? ❑ Yes ❑ No

Who is your GP? _____ Tel No: _____

Address: _____ Postcode: _____

Who is your next of kin? _____ Tel No: _____

Does this person know that you are considering treatment: ❑ Yes ❑ No

The information I have given is to the best of my knowledge correct. I have not knowingly withheld any relevant medical or surgical information.

Patient Name: (block letters): _____

Patient Signature: _____ Date: _____

Practitioner Name: _____ Date: _____