Aqualyx Ages 18 - 60

Medical History Form:

Full Name: _____ Date of Birth: _____
Street Address: _____
Town: _____ Postcode: _____
Contact number: _____ Mobile: _____
Email: _____
Please Confirm if you would like to sign up to our email offers? Yes/No

G.P. Name and Address:_____

Are you attending or receiving treatment from a doctor or specialist If yes, please specify?

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Are you taking any medication, or herbal remedies (including antibiotics, anticoagulants, muscle relaxants, St Johns Wart, Roaccutane)? If yes, please specify?

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Have you undergone any major surgery in the last 12 months? If yes, please specify?

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Are you currently undergoing dental surgery? If yes, please specify?

……

Are you taking blood thinning medication (Aspirin, Plavix, Warfarin)? If yes, please specify?

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Are you allergic to local anaesthetic injections, lignocaine, adrenaline or EMLA/ANESTOP cream? If yes, please specify?

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Do you have any known allergies or a history of anaphylaxis? If yes, please specify?

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Have you suffered from or had any of the following conditions?

Heart Problems including an irregular heartbeat or angina? If Yes, Please Specify?

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High or Low Blood Pressure or circulation problems including Raynaud's Syndrome Epilepsy/Blackouts/fainting? If Yes, Please Specify?

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Blood disorders/leukaemia/lymphoma/anaemia? If Yes, Please Specify?

……..

Autoimmune disease? If Yes Please Specify? (e.g. scleroderma, lupus a Drs consent will be required)

……..

Diabetes? with vascular diseases (microangiopathy)? Y/N

If Yes, Please Specify?

…….

Contact Dermatitis/Eczema? If Yes Please Specify?

…….

Keloids (hypertrophic scarring) or recent scar tissue in the past 6 Months? If Yes Please Specify:

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Easy Bruising: If Yes Please Specify:

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Facial Herpes, Cold Sores, or Acne? If Yes Please Specify:

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HIV: (If Yes please provide a Drs Consent before treatment). Yes/No?

Skin Cancer/ Cancer? If Yes Please Specify: (Please note a year's period cancer free and a Drs consent are required)

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Have you had an allergic reaction to any medications, foods, bee/wasp stings, pets, fish, shellfish? If yes, please specify:

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Are you pregnant/planning pregnancy/engaged in IVF treatment or are you breast Feeding? If yes, please specify:

……..

Severe Adiposities' (adiposities per magna BMI > 30)? Y/N If Yes Please Specify:

……..

Any active infections? Y/N If Yes Please Specify:

……..

Do you have a hepatic disease/liver disease? Y/N if Yes Please Specify:

……

Any other medical conditions that you feel may be relevant, please specify:

Crohn's disease? Y/N

Severe kidney disease? Y/N

Blood clotting or Coagulation? Y/N

Psychiatric illness/Depression? Y/N?

Hypersensitivity against ingredients? Y/N

Do you smoke? Y/N

Do you use sunbeds or sunbathe? Y/N?

What are your expectations of the treatment?

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Some treatments require a Drs consent for certain medications and health problems, please do not be offended, if I request one, your safety to this treatment is my main priority.

Are you, or any of your household showing any symptoms of covid-19? Y/N?

Please do not book your appointment 2 weeks prior to your Covid 19 vaccine and 3 weeks after.

I confirm the health history is accurate and complete. I understand that withholding any medical information may be detrimental to my health and safety during the procedure which the practitioner agrees to undertake. If there are any changes in my medical history, it is my responsibility to advise the practitioner before any further treatments are carried out. I agree that I understand the treatment I am having today, and the possible risks associated with these procedures.

Client Signature: _____

Date _____

Practitioner Signature: _____

Date _____