RENEW

FACIAL COSMETIC SURGERY & AESTHETICS

CONSULTATION FORM

Prior to your appointment, please complete this consultation form. This allows us to get a complete understanding of your history, prepare for your appointment and spend more time discussing a tailored treatment plan during your consultation.

Who referred you? _____

PERSONAL INFORMATION

Name: _____ Date of birth: ___/___/___

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____

Occupation: _____

Pharmacy: _____

EMERGENCY CONTACT

Name: _____

Phone: _____

Relationship: _____

PRIMARY DOCTOR

Name: _____

Phone: _____

Relationship: _____

What treatment concerns would you like to discuss?

- ◯ Fine Lines & Wrinkles
- ◯ Mole Removal
- ◯ Skin laxity
- ◯ Excessive sweating
- ◯ Lip Volume
- ◯ Skin rejuvenation
- ◯ Dark circles/eye rejuvenation
- ◯ Scarring
- ◯ Volume loss / Jowling
- ◯ Hair loss
- ◯ Fat reduction
- ◯ Other _____

Do you have a special event within two weeks of your appointment? ◯ Yes ◯ No

Do you have international travel planned within 2 weeks of your appointment? ◯ Yes ◯ No

MEDICAL HISTORY

Height _____ Weight _____lbs

Do you drink alcoholic beverages ? If so, how often?_____ ◯ Yes ◯ No

Do you have any history of drug use or addiction?_____ ◯ Yes ◯ No

Do you smoke? _____ ◯ Yes ◯ No

Are you taking any medication, supplements or herbal remedies? ◯ Yes ◯ No

If yes please list: _____

Are you taking any GLP-1 medications? (Ozempic, Wegovy, etc) ◯ Yes ◯ No

If yes please list name and dose:_____

Do you have any allergies? ◯ Yes ◯ No

If yes please list: _____

Have you taken antibiotics/steroids in the past 14 days? ◯ Yes ◯ No

Are you pregnant, breastfeeding or trying to conceive? ◯ Yes ◯ No

Have you had a vaccination in the last two weeks? ◯ Yes ◯ No

Are you currently undergoing any investigations for any health concerns? ◯ Yes ◯ No

If yes please list: _____

Have you had any recent surgeries or dental procedures? ◯ Yes ◯ No

If yes please list: _____

Do you suffer from any of the following medical conditions?

- Heart problems
- Jaundice/hepatitis
- Epilepsy/seizures
- Diabetes
- Cancer/chemotherapy
- High/low blood pressure
- Hypoglycemia
- Mental health concerns
- Covid
- Fainting
- HIV
- Blood disorders
- Hormonal imbalance
- Autoimmune disease
- Glaucoma/cataract
- Phlebitis
- Recent dental procedures
- Current or recent antibiotics
- Lambert Eaton syndrome
- Motor Neuron disease
- Heart disease
- Arthritis
- Asthma/bronchitis
- Thyroid problems
- Stomach ulcers
- Permanent implants
- Recent illness
- Bells palsy
- Myasthenia Gravis
- Cold sores

Is there anything else about your health we should know? _____

_____

PREVIOUS TREATMENT HISTORY

It is important for your practitioner to understand your previous treatment history with cosmetic injectables. Please disclose any previous treatments, including the date of your last treatment, treatment areas, products used and number of mls/units.

What treatment concerns would your like to discuss?

- Anti-wrinkle injections
- Skin hydration boosters
- Facelift
- Eyelid surgery
- Dermal filler
- Permanent filler injections
- Rhionoplasty
- Chemical peels
- Collagen stimulators
- Threads
- Maxillofacial surgery
- Red Light Therapy

If yes to any of the above please provide details _____

_____

_____

Have you ever been declined cosmetic treatment? ◯ Yes ◯ No

Have you ever had any adverse reactions to cosmetic treatments? ◯ Yes ◯ No

If yes please describe: _____

What are your primary goals for this consultation? _____

_____

SKIN HISTORY

What products do you currently use?

- ◯ Cleansers / toners
- ◯ Exfoliants/scrubs
- ◯ Serums
- ◯ Moisturiser
- ◯ Sunscreen
- ◯ Make up
- ◯ Masks
- ◯ Eye products
- ◯ None

Have you had any recent sun exposure ? ◯ Yes ◯ No

Do you use sunscreen regularly? ◯ Yes ◯ No

Do you have any allergies or sensitivities to skincare products? ◯ Yes ◯ No

If yes please describe: _____

Are you currently using any skincare products with active ingredients? (Retinol, AHAs, BHAs, Vitamin C) ◯ Yes ◯ No

If yes please list: _____

Have you ever used acne medication? ◯ Yes ◯ No

If yes, when? _____

Do you experience any of the following skin concerns?

- ◯ Acne or breakouts
- ◯ Rosacea or redness
- ◯ Hyperpigmentation
- ◯ Dry & dull skin
- ◯ Fine lines & wrinkles
- ◯ Oily skin
- ◯ Uneven skin tone
- ◯ Enlarged pores
- ◯ Other: _____

How do you heal from a cut? ◯ Brown pigment ◯ Pink then fades to white

Are you using/have you previously used steroid creams? ◯ Yes ◯ No

How did you hear about us? _____

Would you like to be added to our email list for specials and discounts? ◯ Yes ◯ No

I confirm that the information provided is accurate and complete to the best of my knowledge.

Client Signature: _____ Name: _____ Date: _____