Aram
SKIN CLINIC

Client Consultation

Client surname: Client first name:

Address:

Contact number: Email:

While this consultation document may appear to be long, all the questions are essential and need to be answered as many may impact the specific treatment under consideration.

Some considerations and indications may concern treatments, yet therapy may be modified. Treatments are undertaken based on the information you provide.

Would you please ensure all questions you have are answered by your treatment practitioner before treatment commences?

What is your main reason for visiting the clinic today?
Are you currently under doctor's care? YES ☐ NO ☐
Are you allergic to medicines, tapes, foods, creams, or solutions? YES ☐ NO ☐
Do you have any other allergies? (Including hay fever and sinus)? YES ☐ NO ☐ Please describe:
Have you ever had an irritant/allergic reaction to skin products? YES ☐ NO ☐ Please describe:
Have you ever used Roaccutane or other internal medication for acne? YES ☐ NO ☐ ▪ How long were you on the medication? ▪ When did you last take the medication?
Have you ever used Retin A or other rationed-based topical medication? YES ☐ NO ☐ ▪ How long were you on the medication? ▪ When did you last take the medication?
Do you Smoke? YES ☐ NO ☐
Do you sunbathe, use fake tan or solariums? YES ☐ NO ☐ Specify: When was the last time?
Have you ever used home care hydroxy acids or other peeling products on your skin? YES ☐ NO ☐ When was the last time?

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Have you ever had a professional skin peel or resurfacing? YES ☐ NO ☐ When was the last time, and what agent was used?
Do you or have you waxed, shaved, or had electrolysis on the area of proposed treatment? YES ☐ NO ☐ When was the last time?
Have you ever had any surgery in the last six months? YES ☐ NO ☐ Date: Details:
Have you ever had dermal filler in the previous four weeks? YES ☐ NO ☐ Dates: Details:
Have you ever had Cortisone, steroids, hormone tablets, patches, or injections? YES ☐ NO ☐ Date: Details:
Do you have diabetes? YES ☐ NO ☐ Type 1 ☐ Type 2 ☐ Are you on insulin and/or oral medications?
Have you suffered any serious illness in the past five years? YES ☐ NO ☐ Date: Details:
What are you currently using on your skin?

Do you have or ever had any of the following

Migraine		Open wounds		Epilepsy	
Hear Condition		High blood pressure		Cold Sores	
Blood disease		Pacemaker		Pregnant / Breastfeeding	
Blood clots		Hepatitis		Bleeding disorder	
Asthma		Cancer / Melanoma		Active inflammation	
Eczema		Psoriasis		Active infection	
Thyroid condition		Lupus		Keloid scarring	
Easily bruised		Hypertrophic		Metal pins/plates or implants	
Pigmentation disorder		Lack of sensation in the area		Genital herpes	

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Are you taking any of the following? If YES, please name the medication

Anti-Coagulants	Thyroid Medication	Tranquillisers/ Antipsychotics	Other
Vitamins	Herbal Supplements	Photosensitising medication	

Have you had significant sun exposure n the treatment area in the past six weeks (including solarium)

NO ☐ YES ☐ Where?

Do you use a spray tan or tinted moisturiser in the treatment area? NO ☐ YES ☐

Do you have tattoos or permanent make-up in the treatment area? NO ☐ YES ☐

Do you have any medical implants? NO ☐ YES ☐

How much water consume daily? Almost None ☐ ½ litre ☐ 1 litre ☐ more than1 litre ☐

How many caffeine beverages are consumed daily? None ☐ 1-3 ☐ 3-5 ☐ more ☐

How many glasses of alcohol per week? None ☐ 1-3 ☐ 3-5 ☐ more ☐

Are you on a restricted diet? NO ☐ YES ☐ Please indicate.

Are you presently under the care of the doctor? NO ☐ YES ☐ DR. Name:

Please indicate your stress level. Low ☐ Medium ☐ High ☐

Do you exercise regularly? NO ☐ YES ☐

Regular menstruation ☐

Oral contraceptive ☐

Pregnant / Planning ☐

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I understand the importance of following the home care instructions given by my Practioner.

I understand the importance of providing correct information to the practitioner to decide on the suitability or modification of treatment, and I will review this consultation information at each visit.

Printed Name	Signature	date

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