Medical Questionnaire

**Client Name……………………………………………………..…… [Male / Female] Date of Birth…………………**

**Contact Tel…………………………………………... Address……………………………………………………….……………………….**

**Postcode……….………………. Email …………………………..…….................**

PLEASE READ CAREFULLY and CIRCLE the appropriate answer. Ensure that you are satisfied with the explanations and information given regarding your condition / treatment, and that you understand that it is your right and responsibility to ask further questions if anything is unclear. Note that you can ask for a chaperone or the discontinuation of proceedings at any time. By signing, you confirm that you have been given sufficient information to understand your treatment and the products used, including contraindications and adverse effects as well as off-license usage; and that you consent to us keeping a copy of this document on record / computer; and that you have you read the INFORMATION & RISK (WHAT TO EXPECT) leaflet / booklet.

**Do we have your consent to take and keep photographs of you? Yes / No**

CONFIDENTIAL MEDICAL HISTORY QUESTIONNAIRE

Answer YES or No to the following questions; if YES, give more details overleaf. If you do not understand a question, please ask.

* Are YOU Attending/receiving treatment from a doctor, clinic, hospital or a specialist **Yes / No**
* Taking medicines (Tablets, creams, ointments, injections, birth control, etc.)If “yes”, please specify. **Yes / No**
* Taking supplements, or medicinal herbs? If “yes”, please specify. **Yes / No**
* Taking or haven taken steroids/cortisone in the past two years **Yes / No**
* Allergic / Anaphylaxis to medicines (penicillin, etc.) **Yes / No**
* Allergic to any materials (Elastoplast, latex, rubber, etc.) **Yes / No**
* Pregnant or on IVF; or nursing / breastfeeding **Yes / No**
* Due to start medical treatment / operation within the next 4 weeks **Yes / No**
* Due to Fly / travel within the next 2 days **Yes / No**
* Have YOU Had rheumatic fever or chorea **Yes / No**
* Had jaundice, liver disease, or hepatitis A, B or C **Yes / No**
* Any heart problems (previous heart attack, chest pains, heart murmur?) **Yes / No**
* Had blood tests for HIV or hepatitis **Yes / No**
* Tested positive for HIV or hepatitis **Yes / No**
* Ever had your blood refused for a Blood Transfusion Service **Yes / No**
* Had a bad reaction to general or local anaesthetic **Yes / No**
* Any blood disorders (sickle cell anaemia, thalassaemia) **Yes / No**
* Any blood clotting disorders (thrombosis, embolism) **Yes / No**
* Ever been hospitalised? If “yes”, please specify when and what for **Yes / No**
* Received any antibiotics in the last 3 weeks **Yes / No**
* Had any operation in the last 4 weeks (especially facial surgery) **Yes / No**
* Ever been diagnosed with Eaton Lambert Syndrome or Bell’s Palsy **Yes / No**
* Ever been diagnosed with any other long term medical condition **Yes / No**
* Ever had Botulinum Toxin injected before and was there any problem **Yes / No**
* Do YOU Suffer from Skin condition/disease (e.g., Eczema, Rosacea, Psoriasis, etc) **Yes / No**
* Suffer with muscle disorders (muscular dystrophy, multiple sclerosis, etc) **Yes / No**
* Have a pacemaker or have you had any form of heart surgery or problems **Yes / No**
* Suffer from asthma, hay fever, eczema or other allergies **Yes / No**
* Suffer from any lung disease (emphysema, chronic bronchitis, etc) **Yes / No**
* Suffer from any neurological disorders (epilepsy, myasthenia gravis) **Yes / No**
* Suffer from any autoimmune disorder? **Yes / No**
* Suffer from any endocrine disorders (diabetes mellitus, thyroid disease, etc.) **Yes / No**

**SIGNED BY CLIENT: ……………………………………….. DATE: ………………………………………..**

* Suffer from high / low blood pressure ? **Yes / No**
* Suffer with fainting attacks, blackouts or giddiness **Yes / No**
* Suffer from liver disease **Yes / No**
* Suffer from any skeletal or joint disease (arthritis, scoliosis, kyphosis) **Yes / No**
* Have you received any vaccination (including COVID-19) in last 3 weeks? **Yes / No**
* have you had an post inflammatory hyperpigmentation as a result of a treatment before? **Yes/no**
* Have you had any Hypo-pigmentation disorders? **Yes/No**
* Do you have any tattoo’s in the area’s to be treated? **Yes/no**
* Have you recently had any other hair removal treatments? **Yes/No (if you have stated yes please comment when and which treatment below) -**

**SIGNED BY CLIENT: ……………………………………….. DATE: ………………………………………..**

**CONSENT is GIVEN for:**

PRODUCT……………………………… TREATMENT.…..……...................

Procedure date……………………..

**Read this document carefully and if you agree that you have read the information leaflet; the therapist has explained everything about the above-named procedure to your satisfaction; have checked that the information on this form and the Client Registration form are correct and only if you approve and consent, sign below.**

1. I authorize and consent to treatment for aesthetic effect and rejuvenation using the above procedure.

2. I have been advised of the purported advantages and disadvantages associated with the above procedure and agree that the therapist has adequately explained the proposed procedure and alternatives.

3. I understand that treatment experience and results with this procedure varies from client to client and as with all beauty therapy procedures, no guarantees can be made regarding the eventual outcome.

4. I understand that the primary benefits are for personal aesthetic and rejuvenation effect and not for medical or essential health reasons.

5. I am satisfied that I had enough “cooling off” opportunity to enable me to make a rational and sober decision.

6. I accept that the cosmetic improvements are secondary to a healthy lifestyle and sensible diet and that exercise regimes must be maintained.

7. I have been given sufficient opportunities to ask questions and seek further information and have received satisfactory answers to all of them.

8. I accept, although rare, that adverse outcomes such as pain, bleeding, bruising, infection, numbness, scaring and lumps may occur, and that some scars or lumps may be permanent.

9. I am aware that with relatively new procedures, there are no long term studies on adverse effects and complications.

10. I consent to the use of topical or local anaesthesia if required.

11. I authorize the taking of photographs and understand that these photographs cannot be displayed without my consent.

12. I understand that I receive this optional treatment (which is unnecessary or life-saving) from independent private therapists who are not affiliated with NHS or Public Agencies in the UK.

13. I give my consent that, in the unlikely event of a “needle stick injury” to the Therapist, my blood can be tested for any blood-borne transmissible disease.

14. I hereby indemnify and hold harmless, the Treating Therapist (named below) & Clinic where the procedure was done from any liability, damages, cost and expenses arising from or out of the NPR treatment.

15. I understand that I can refuse treatment at any time; and may ask to have a relative, friend or another therapist present during the procedure.

Under the new data protection laws, it is vital that all individuals understand how their personal data is being used. We keep all information for 10 years to comply with insurance policies and to ensure our clients’ health and wellbeing in the event of an adverse effect/reaction. Your information is never passed on to third parties.

**SIGNED BY CLIENT: ……………………………………….. DATE: ………………………………………..**

**TO BE COMPLETED BY** **Practitioner / Therapist / Prescriber**

**CONSULTATION RECORD & REQUISITION**

Confirmation of consent (for completion by Therapist / Prescriber when Client is admitted for procedure / or seen for face-to-face consultation). I confirm that I have explained to the client the procedure and local anaesthesia required in terms, which in my judgment are suited to the understanding of the client. I have explained the intended benefits and that it is cosmetic and not medical and have discussed with the client all possible serious or frequently occurring risks and complications.

Bleeding Disease **Yes / No** Adverse Reaction to Local Anaesthetic **Yes / No** Latex Allergy **Yes / No**

Drug Allergy……..…………………………………….… Past Medical History/Long Term Medical Condition …………………………..…………………

Medication………………..…………………………..…

**I confirm that the Client has no further questions and wishes the procedure to go ahead.**

**Consulting & Treating Practitioner / Therapist / Prescriber (Name): ………………………….……..**

**Dates & Signature: ….…………………….…….**

**Patch test date and settings used: (photographic evidence of patch test also required)**

RECORD PROCEDURE:

Time (00:00) in margin

□ CONSENT OBTAINED

□ PREMED (if applicable):

□ AREAS TREATED: Face; Hands; Feet; Décolletage; Neck; Arms; Legs;

Others:

□ CLEANSED AREA: Remove Make-Up

□ PHOTOS: front, back, oblique and side.

□ CLEANSED 2nd TIME: Disinfectant wipes / solution

□ TOPICAL ANAESTHETIC: EMLA / Ametop / LMX-4

**□ PROCEDURE NOTES:**

**□ CLIENT EXPERIENCE: □ IMMEDIATE RESULT: □ AFTERCARE:**

**□ RESULTS □ COMPLICATIONS □ CLIENT SATISFACTION**

□ **OTHER COMMENTS**

Settings used: Outcome of the treatment:

**SIGNED BY CLIENT: ………………………………………. DATE: ……………………………………….**