Blemish Removal Procedure Consultation

Client Information

Name: _____

Address:_____

_____

Email:_____

Tel: _____

Date of Birth: _____ Occupation: _____

Medical Information

Doctor's name: _____ Tel no: _____

Doctor's Address:

_____

_____

Medical History:

_____

_____

Are you currently under medical care? Y/N

If so please provide details:

_____

_____

List any medications you take:

_____

_____

Do you smoke? Y/N

Do you drink alcohol? Y/N If Yes, how many units per week _____

Contra-indications: Prevent (Please circle)

Cochlear Implants Haemophilia Keloid Scarring Pacemaker

Other: _____

Contra-indications: Restrictive (Please Circle)

Asthma/Respiratory Disorder Diabetes(type2) High Blood Pressure

Recent Scar Tissue Auditory Devices Dermographia Laser/IPL(recent)

Rosacea(active) A.I.D.S/H.I.V Drugs(Steroids or blood thinners)

Metal Plater/Pins Skin Disease/Disorder Cancer Epilepsy

Minor (Undre18) Swelling/Oedema Bad Circulation Nervous

Fitzpatrick V&VI Sunburn (in area) Dermabrasion(recent) Heart Condition

Phlebitis/Thrombosis (in area) Diabetes(type 1) Hepatitis

Pregnancy (1st trimester)

Other:

_____
_____

Skin Analysis (incl Fitzpatrick Scale)

Any previous blemish removal? Y/N

If Yes, please give dates and clinic details:

_____
_____

Any Tissue Damage observes Y/N

If Yes, please specify

_____
_____

Speed of healing_____

Prone to Pigmentation Y/N _____

Existing Pigmentation Y/N _____

Skin Type (Circle)

Combination Normal Dehydrated Mature Oily Dry Sensitive

Any allergies (please circle)

Topical/local anaesthetic Latex Cosmetics Metal Products Vinyl

Please give details _____

Procedure (please circle)

Age Spot Milia Syringoma Telangiectasia Plane/Common Wart

Verrucae Skin Tag Dermatosis Papulosa Nigra Xanthelasma

Spider Naevus

Other: _____

Before and After Photos taken Y/N

If Yes date: _____

Patch Test done where required Y/N

Details: _____

Date: _____

Client signature: _____

Technician Signature: _____