

PLEASE COMPLETE ALL 4 PAGES AND SIGN BEFORE CONSULTATION

FREEDOMHEALTH  
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Patient Name (Mr/Mrs/Miss/Ms/Other) <input type="text"/>	Address: <input type="text"/>
Post Code: <input type="text"/>	DOB: <input type="text"/>
Mobile Tele: <input type="text"/>	Next of kin: (Mr/Mrs/Miss/Ms/Other) <input type="text"/>
Name: <input type="text"/>	Relationship: <input type="text"/>
Weight: <input type="text"/>	Email <input type="text"/>
Where did you hear about us: <input type="text"/>	Can we contact you: <input type="text"/>
Do you suffer from any allergies <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you a history of anaphylactic reaction (Severe allergic reaction)? <input type="checkbox"/> Yes <input type="checkbox"/> No

1. Are you currently taking any medication, including homeopathic remedies?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Do you suffer form any heart disease or angina?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Do you have high blood pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Are you prone to fainting attacks/low blood pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Do you suffer for stress/anxiety attacks?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Do you have a heart pace maker fitted?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Do you have any metal(s) inserted in your body e.g. pins/plates/stents?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Do you ware a hearing aid or have an inner ear implant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Are you taking HRT –hormone replacement therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Are you pregnant / trying to become pregnant or breast feeding?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Do you suffer form asthma or any respiratory disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Are diabetic?	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. Do you bruise easily?	<input type="checkbox"/> Yes <input type="checkbox"/> No

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14. Do you have epilepsy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
15. Do you suffer from any autoimmune disease e.g. Lupus?	<input type="checkbox"/> Yes <input type="checkbox"/> No
16. Are you currently receiving any dental treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
17. Do you have any dental implants?	<input type="checkbox"/> Yes <input type="checkbox"/> No
18. Do you suffer from any active skin conditions e.g. psoriasis, eczema?	<input type="checkbox"/> Yes <input type="checkbox"/> No
19. Do you suffer from urticaria or have a history of skin rashes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
20. Do you suffer form herpes simplex virus i.e. cold sores?	<input type="checkbox"/> Yes <input type="checkbox"/> No

If you answered YES to any of the questions please give further information including dates:	Question No

Please state any other relevant medical history of note including operations and treatments:	

**Skin History**

21. Do you currently use any retinol / vitamin A based products?	<input type="checkbox"/> Yes <input type="checkbox"/> No
22. Have you used Accutane (Roaccutane) within the last six months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
23. Are you using any Glycolic based products?	<input type="checkbox"/> Yes <input type="checkbox"/> No
24. Are you sensitive to alcohol based products?	<input type="checkbox"/> Yes <input type="checkbox"/> No
25. Have you ever had a skin reaction from any skin preparation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
26. Do you suffer with Hyper (dark) or Hypo (light) pigmentation changes 27. of the skin?	<input type="checkbox"/> Yes <input type="checkbox"/> No
28. Do you have a history of keloid / hypertrophic scarring?	<input type="checkbox"/> Yes <input type="checkbox"/> No
29. Have you ever had dermal facial fillers e.g. Restylane / Collagen or 30. similar?	<input type="checkbox"/> Yes <input type="checkbox"/> No
31. Have you recently undergone any facial laser treatments?	<input type="checkbox"/> Yes <input type="checkbox"/> No
32. Have you ever had Botox / Dysport treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
33. Have you ever had a form of laser treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No

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34. Have had recently had any facial waxing / depilatories?	<input type="checkbox"/> Yes <input type="checkbox"/> No
35. Have you recently used a sunbed or sunbathed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
36. Do you use fake tan on you face or body?	<input type="checkbox"/> Yes <input type="checkbox"/> No
37. Have you recently had IPL / hair removal?	<input type="checkbox"/> Yes <input type="checkbox"/> No
38. Have you recently had electrolysis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
39. Do you tan easily?	<input type="checkbox"/> Yes <input type="checkbox"/> No

If you answered YES to any of the questions please give further information including dates:	Question No

<b>Describe Your Skin</b>			
Normal	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fine Lines	<input type="checkbox"/> Yes <input type="checkbox"/> No
Melasma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Acne	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comedones	<input type="checkbox"/> Yes <input type="checkbox"/> No	Large Pores	<input type="checkbox"/> Yes <input type="checkbox"/> No
Firm	<input type="checkbox"/> Yes <input type="checkbox"/> No	Small Pores	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sallow	<input type="checkbox"/> Yes <input type="checkbox"/> No	Freckled	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dry	<input type="checkbox"/> Yes <input type="checkbox"/> No	Wrinkled	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rosacea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hyperpigmentation	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breakouts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hypopigmentation	<input type="checkbox"/> Yes <input type="checkbox"/> No
Thin	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sagging	<input type="checkbox"/> Yes <input type="checkbox"/> No
Uneven / Blotchy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sun-Damaged	<input type="checkbox"/> Yes <input type="checkbox"/> No
Oily	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarring	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cysts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Florid	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Describe Your Skin Tone</b>			
Light White	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dark Yellow	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pale White	<input type="checkbox"/> Yes <input type="checkbox"/> No	Light Yellow	<input type="checkbox"/> Yes <input type="checkbox"/> No

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Olive	<input type="checkbox"/> Yes <input type="checkbox"/> No	Reddish	<input type="checkbox"/> Yes <input type="checkbox"/> No
Medium	<input type="checkbox"/> Yes <input type="checkbox"/> No	Black	<input type="checkbox"/> Yes <input type="checkbox"/> No
Light Brown	<input type="checkbox"/> Yes <input type="checkbox"/> No	Freckled	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Describe Your Natural Hair Colour</b>			
Dk/Lt Blonde	<input type="checkbox"/> Yes <input type="checkbox"/> No	Red	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lt/Md/Dk Brown	<input type="checkbox"/> Yes <input type="checkbox"/> No	Black	<input type="checkbox"/> Yes <input type="checkbox"/> No
Silver	<input type="checkbox"/> Yes <input type="checkbox"/> No	White	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Describe Your Daily Skin Care Routine**


**What Skin Care Products Do You Normally Use?**


**Do you require a chaperone?**

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**I Have Been Warned That This Might Happen After Treatment In The Box Below:**

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I confirm that I have completed my medical history in full, not leaving any medical history undisclosed, and understand that failure to declare all of my medical history details may result in failure of the treatment and increase the risk of possible complications.

<b>Signature</b>	<b>Date</b>	<b>Time</b>
<b>Print Name</b>		
<b>Witness</b>	<b>Date</b>	<b>Time</b>
<b>Print Name</b>		

**Treatment Plan**


<b>Signature</b>	<b>Date</b>	<b>Time</b>
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