PATIENT QUESTIONNAIRE

WHAT'S THE MAIN REASON FOR YOUR AESTHETIC CONSULTATION?

WHICH OF THESE STATEMENTS ARE MOST APPLICABLE TO YOU?

☐ I would like to look better for my age.

☐ I would like to change something that has been bothering me for a long time.

☐ I would like to look more attractive.

HAVE YOU HAD AN AESTHETIC CONSULTATION OR TREATMENT BEFORE?

☐ Yes ☐ No

HOW OFTEN DO YOU THINK ABOUT HAVING AN AESTHETIC TREATMENT?

☐ Most days ☐ Weekly ☐ Monthly

WHEN I THINK ABOUT MY APPEARANCE, I FEEL THAT I LOOK:

(Please select three)

☐ Dull ☐ Tired ☐ Sad ☐ Angry ☐ Old

☐ Fresh ☐ Happy ☐ Bright ☐ Unattractive

On a scale of 1 – 10, 1 being desperately unhappy, and 10 being extremely happy, how satisfied are you with your overall appearance?

Desperately unhappy 1 2 3 4 5 6 7 8 9 10 Extremely happy

On a scale of 1 – 10, 1 being desperately unhappy, and 10 being extremely happy, how satisfied are you with your skin?

Desperately unhappy 1 2 3 4 5 6 7 8 9 10 Extremely happy

AFTER THE TREATMENT, I WOULD LIKE TO FEEL (Please select three):

☐ Fresher ☐ Happier ☐ Brighter ☐ More awake ☐ More youthful

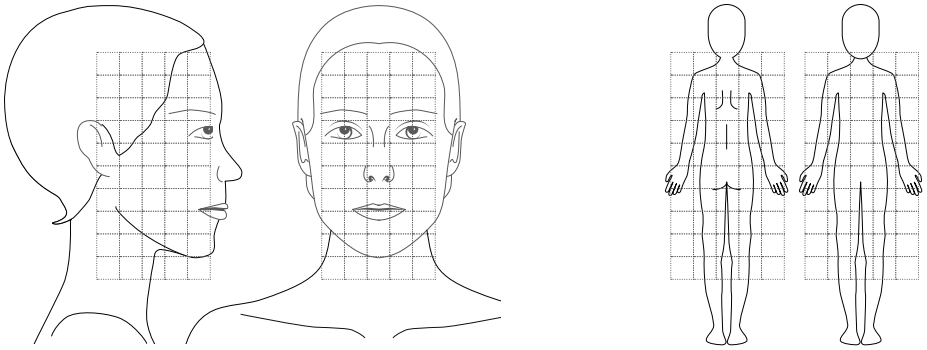
☐ Slimmer ☐ More attractive ☐ More luminous ☐ More confident

Please turn over.

FROM YOUR SELECTIONS, LIST YOUR THREE DESIRED OUTCOMES IN ORDER OF PRIORITY:

1. _____
2. _____
3. _____

PLEASE TICK THE AREA(S) THAT YOU ARE CONCERNED ABOUT?



WHICH OF THESE CLINIC TREATMENTS INTEREST YOU?

UPPER SKIN IMPROVEMENT	DEEPER SKIN IMPROVEMENT	FACIAL IMPROVEMENT	BODY IMPROVEMENT
☐ Skincare	☐ Skin tightening	☐ Muscle relaxant injections	☐ Laser hair removal
☐ Chemical Peels	☐ Skin injectables	☐ Facial fillers	☐ Thread vein removal
☐ IPL	☐ Micro-needling	☐ Facial threads	☐ Hair replacement
☐ Microdermabrasion	☐ Mesotherapy	☐ Nose augmentation	☐ Labiaplasty
☐ Facials	☐ Laser	☐ Brow correction	☐ Fat reduction
☐ Dermaplaning		☐ Eyelid correction	☐ Breast augmentation
☐ Pigment reduction – cryotherapy		☐ Fat reduction – chin	☐ Tummy tuck
		☐ Ear correction	☐ Arm lift
		☐ Capillary removal	☐ Buttock augmentation

HOW DID YOU HEAR ABOUT US?

☐ My doctor ☐ Adverts ☐ Recommendation ☐ Search engine ☐ Social media

PATIENT DETAILS

NAME: DATE OF BIRTH:

PHONE: EMAIL:

ADDRESS:

☐ I hereby consent to providing the above data for use in respect of my treatment. In the unlikely event that I experience any adverse reaction, I further consent for this information to be shared with AlumierMD, for further investigation and advice.

PRACTITIONER NAME: DATE:

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PATIENT PROFILE

In order for your practitioner to hyper-customise your consultation and treatment, we need a comprehensive understanding of your medical history and lifestyle. Please answer the following questions honestly and with as much detail as possible.

Name: _____

DOB: _____

Gender: Male/Female/Prefer Not to Say

Patient Dr: _____

Patient Dr Address: _____

MEDICAL HISTORY

Complete this form by marking a ✓ or X in each box.

- ☐ Are you pregnant, IVF, or breastfeeding?
- ☐ Have you taken Roaccutane in the last six months?
- ☐ Do you have a skin infection/open wound in the treatment area?
- ☐ Are you allergic to Aspirin (acetylsalicylic acid)?
- ☐ Have you had a cold sore the last 7 days and/or have you ever had a cold sore? If 'yes', how frequently/easily do you get them? When was your last cold sore?

  _____
- ☐ Are you currently under the care of a medical professional (dermatologist/oncologist/obstetrician/endocrinologist)? If 'yes' please provide more details.

  _____
- ☐ Have you ever been treated for skin cancer? If 'yes' please provide more details.

  _____
- ☐ Are you currently taking any prescription medicines (antibiotics/antidepressants/blood thinners)? If 'yes' please provide more details.

  _____
- ☐ Are you currently using any topical prescription medicines (retinoic acid/topical antibiotic/topical steroids)? If 'yes' please provide more details.

  _____
- ☐ Do you have any illnesses or health conditions? If 'yes' please provide more details.

  _____
- ☐ Have you ever been diagnosed with a skin condition? If 'yes' please provide more details.

  _____
- ☐ Do you have any undiagnosed skin lesions? If 'yes' please provide more details.

  _____

Alumier MD

PATIENT PROFILE

- [ ] Do you have any allergies? If 'yes' please provide more details.

AESTHETIC TREATMENTS

- [ ] Have you had laser/IPL/radio frequency/ chemical peel in the last 2 weeks? If 'yes' please provide more details.
- [ ] Have you had filler injections in the last two weeks? If 'yes' please provide more details.
- [ ] Have you had neurotoxin/filler/ microdermabrasion/enzymatic peeling/waxing/ threading etc. in the last 7 days? If 'yes' please provide more details.
- [ ] Have you shaved the area to be treated in the last 24hrs?
- [ ] Have you ever used any skincare products that caused an adverse reaction? If 'yes' please provide more details.

LIFESTYLE

- [ ] Do you smoke? If 'yes' how many cigarettes/ cigars a day?
- [ ] Do you drink alcohol? If 'yes' how many units a week?
- [ ] Do you drink water? If 'yes' how many glasses a day?
- [ ] Do you follow a particular diet? If 'yes' please provide more details.
- [ ] Are you physically active? If 'yes' please provide more details.

CURRENT SKINCARE

- [ ] Are you using AHAs/BHAs/non-prescription retinol in your current skincare routine? If 'yes' please provide more details.
- [ ] Have you used retinol (prescription or non-prescription) in the last 7 days? If 'yes' how many days ago?

FOR CONSIDERATION REGARDING YOUR TREATMENT

- [ ] Do you consider yourself to have a disability? If 'yes' please provide more details.
- [ ] Do you wear contact lenses?
- [ ] Do you wear a wig or hairpiece?
- [ ] Do you have semi-permanent make-up?
- [ ] Is there anything else at all that your practitioner may wish know or consider during your consultation or treatment?
- [ ] I hereby declare that all the information I have given on this form is correct and truthful.
- [ ] I consent to this data being collected and to the clinic passing this information to AlumierMD.

SIGNED PATIENT _____ DATED _____

SIGNED PRACTITIONER _____ DATED _____