Patient Questionnaire

Please complete the following questionnaire.

Briefly describe your major concerns and feelings about your appearance

** This question will be required*

What are you looking to achieve by way of changes to your appearance and why?

** This question will be required*

How are you currently managing this issue?

** This question will be required*

What other options have you considered [insert details]?

** This question will be required*

Have you received any other health advice in relation to this issue (including, but not limited to, cosmetic procedures that might be available)

** This question will be required*

How much time do you spend each day worrying about your appearance?

** This question will be required*

less than an hour

1–2 hours

multiple times a day, hours

Does your appearance impact your ability to work /study / or socialise or stop you doing things? Please give us more information.

** This question will be required*

Do you have ANY repetitive behaviours or thoughts concerning your appearance, eg mirror looking, thoughts, comparing self to others, rituals, other?
** This question will be required*

Details:
** This question will be required*

Do you have any specific concerns or fears regarding treatment?
** This question will be required*

PREVIOUS AESTHETIC TREATMENTS OR SURGERY- Who, Where, What?
Give brief details of previous procedures you have had, including injectables / fillers / surgery . List the areas treated , who performed the treatment and when, and the products used, if known .
** This question will be required*

Please list any complications or adverse reactions to previous treatments
** This question will be required*

Give details of cosmetic procedures you feel were not a satisfactory outcome . If none write NIL
** This question will be required*

Have you ever had THREADS permanent / non permanent placed in your face or neck or body?
** This question will be required*

Have you ever had PERMANENT FILLERS in your face or body?
** This question will be required*

ALLERGIES / REACTIONS

What medications are you allergic to / react to ?
Write NIL if none.

** This question will be required*

CURRENT MEDICATIONS

List the medications you are taking currently , including non prescription , vitamins and supplements. Write NIL if none

** This question will be required*

MEDICAL AND SURGICAL HISTORY

Do you now , are you or have you had

** This question will be required*

allergic reactions, hives / urticaria , rashes

neurological diseases such as multiple sclerosis, eaton lambert syndrome, myasthenia gravis

Blindness or Vision loss in one or both eyes / eye disease

psychological condition eg depression, anxiety, BPD

feel faint during procedures or blood tests

immunosuppressed , due to a disease or medication

Recent dental work- crowns, caps, implants, root canals in the past 3 months

skin infections , abcesses , skin conditions such as eczema, psoriasis

auto immune conditions eg lupus, arthritis, thyroid , bowel disease,

Depression/ anxiety or other mental health illness

worry about your appearance multiple times a day / affects your day to day ability to live happily, work or socialise

cancer

diabetes

clotting, bleeding disorder, deep venous thrombosis, PE

asthma

heart disease , high blood pressure, heart murmur , valve condition

smoke cigarettes

surgery

NONE OF THE ABOVE , I have always been in good health

Please provide further details about any box you checked above. Write NIL if you did not check any boxes.

** This question will be required*

Are you currently pregnant or breast feeding or trying to get pregnant?

** This question will be required*