

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

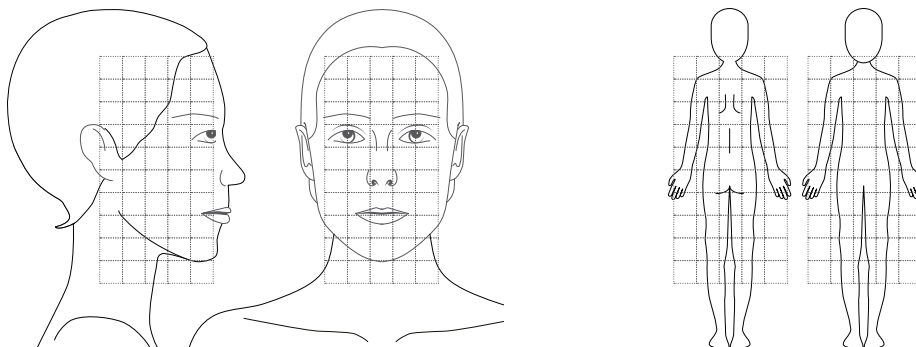
☐
More confident

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: _____

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.

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 _____