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| **PERSONAL INFORMATION** |

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| **Full Name:** | **Date of Birth:** |
| **Address:****Postcode:** |
| **Telephone:** | **Mobile: □ tick if we may send you text reminders for future appointments** |
| **Email:** 🞎 tick if you would like to receive our e-newsletter (approx every 2 months) | **Occupation:** |

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| **MEDICAL HISTORY** |

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|  | **NO** | **YES** | **FURTHER INFO** |
| Are you currently seeing a doctor for any medical condition? |  |  |  |
| Are you taking any medication? |  |  |  |
| Do you take warfarin or aspirin? |  |  |  |
| Have you ever taken Roaccutane (acne treatment)? |  |  |  |
| Do you have any allergies? |  |  |  |
| Do you have a history of cold sores or lip herpes? |  |  |  |
| Are you pregnant or breast-feeding? |  |  |  |
| Have you had cosmetic surgery? |  |  |  |
| Have you had cosmetic treatment (inc. Botox/fillers)? |  |  |  |

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| **AESTHETIC SELF-ASSESSMENT** |

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| When I look in the mirror, I believe I look (please circle) | YOUNGER THAN I AM | THE AGE I AM | OLDER THAN I AM |
| When you look in the mirror how concerned are you about wrinkles? | NOT CONCERNED | SOMEWHAT CONCERNED | VERY CONCERNED |

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| **Please tick (below) all the concerns/treatment of interest below** | **Please mark any specific areas** |
|  | Lines and wrinkles  |  | Liver spots/age spots |  |
|  | Forehead  |  | Hands |
|  | Frown |  | Thread veins – face |
|  | Crow’s feet / laughter lines |  | Acne |
|  | Tired look |  | Acne scarring |
|  | Loss of fullness in the cheeks/temples |  | Saggy jawline/loose jowls |
|  | Nose shape |  | Skincare advice/products |
|  | Lip shape/fullness |  | Neck or décolletage |
|  | Lip-lines/smoker’s lines |  | Hair removal |
|  | Mouth corners |  | Localised fat reduction |
|  | Red or blotchy skin |  | Excessive perspiration |

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| **How did you hear about us?** |
|  | Website  |  | Doctor/GP |  | Advert |
|  | Friend/relation (name?) |  | Other (if so where?) |  |  |

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| **Why did you choose Mulberry House Clinic & Laser Centre?** |
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| **Signature:** | **Date:**  |