PATIENT INFORMATION QUESTIONNAIRE

FOREVER FLAWLESS AESTHETICS

PERSONAL INFORMATION

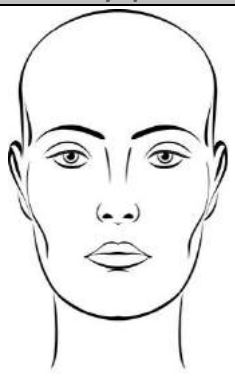
Full Name:	**Date of Birth:**
Address: **Postcode:**	
Telephone:	**Mobile:** ☐ *tick if we may send you text reminders for future appointments*
Email: ☐ *tick if you would like to receive our e-newsletter (approx every 4 weeks)*	**Occupation:**

MEDICAL HISTORY

	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. fillers)?			

AESTHETIC SELF-ASSESSMENT

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

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	

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

Why did you choose Forever Flawless Aesthetics Ltd?

Signature:	**Date:**