The Hogarth MediSpa

Patient record

Patient's Name: _____

DOB: ___/____/_____

Title _____ First Name _____

Surname _____ DOB ____/____/_____

Address _____

Postcode _____ Mobile number _____

Email _____

Occupation _____

What is your height (cm)? _____ Weight (kg) _____

Do you smoke? Yes – No If so, how many a day? _____

Do you drink alcohol? Yes – No If so, how many units a week? _____

Do you take regular exercise ? Yes – No If so, what type? _____

Do you follow any special diet? _____

Medical History

Are you currently pregnant or breast feeding? Yes – No

Do you have any known allergies? Yes – No

If so, please give details: _____

Are you currently taking any medications (pain killers, coagulation inhibitors, steroids, herbal preparations, any supplements)? Yes – No

If so, please give details: _____

Have you suffered from any of the following?

Auto-immune disease	Yes – No	Skin cancer /melanoma	Yes – No
Facial cold sores	Yes – No	Angina, cardiac infarction	Yes – No
Thyroid problems	Yes – No	Epilepsy	Yes – No
Depression	Yes – No	Facial palsy or stroke	Yes – No
Diabetes	Yes – No	HIV, hepatitis	Yes – No
Acne or psoriasis	Yes – No	Bleeding disorders	Yes – No
Pigment disorders	Yes – No	Severe allergy	Yes – No
Increased scar formation	Yes – No	Asthma	Yes – No
Herpes infections	Yes – No	Veneral disease	Yes – No

Have you previously received any aesthetic treatments (eg. Laser, peels, dermabration, etc.)? Yes – No

If so, please give details: _____

Have you had any treatment with fillers or botolinum toxin? Yes – No

If yes, which treatment, what areas and when, and side effects?_____

_____

Have you taken Roaccutane or Isotretionin (for acne) in the past 12 months?

Yes – No

Have you had any major surgery in the last 6 weeks? Yes – No

Do you have a phobia about blood or needles? Yes – No

Are you prone to bruising? Yes – No

Do you use sunbeds? Yes – No

Have you ever been sun-burnt to the point of blistering? Yes – No

Do you have any disease in your family history? Yes – No

If so, please give details: _____

Have you ever received local anaesthetic injections at your dental practice?

Yes – No

If yes, were there any problems with that? Yes – No

Do you have any worries or concerns about treatments or anything else that you wish to tell us? Yes – No

_____

If the answer is yes to any of the above, Dr Bela may ask for further details.

Treatment may be refused if it is not considered in your own interest to proceed.

Thank you for providing this information. All patient notes, treatment details and contact information are confidential.

The information that I have given is to the best of my knowledge correct. ☐

I have not knowingly withheld any medical or surgical information. ☐

I agree to inform my practitioner of any changes to my medication or health in the future. ☐

Patient's Name _____

Signature _____ Date _____