Personal Information

☐MR ☐MRS ☐MISS ☐MS ☐MASTER ☐DR ☐OTHER:

FAMILY NAME: _____

FIRST NAME: _____

DATE OF BIRTH: _____ SEX: ☐MALE ☐FEMALE

OCCUPATION: _____

HOME ADDRESS: _____SUBURB: _____POSTCODE:_____

HOME PHONE: _____WORK PHONE: _____MOBILE PHONE: _____

Which would you prefer us to contact you on? ☐Home ☐Work ☐Mobile

☐ **I consent for Whitsunday Cosmedic Skin Clinic to communicating via SMS text message for Reminders**

EMAIL ADDRESS: _____

☐ **I consent for Whitsunday Cosmedic Skin Clinic to communicating via EMAIL for promotions and offers**

Emergency Contact Information

NAME: _____ PHONE: _____

Medical Information -PLEASE COMPLETE ALL SECTIONS

CURRENT MEDICATIONS (including herbal) OR **No Medication☐**

_____

_____

ALLERGIES AND REACTIONS OR **Nil Known☐**

_____

_____

MEDICAL HISTORY OR **No Significant History☐**

_____

_____

SURGERIES OR **Nil☐**

_____

_____

Pacemaker/Defibrillator?	**Y**	**N**	Epilepsy/Lupus/Porphyria?	**Y**	**N**
Metal Implants?	**Y**	**N**	Cold Sores/Herpes Simplex?	**Y**	**N**
Current/History of Skin Cancers?	**Y**	**N**	Diabetes?	**Y**	**N**
Pregnant/Trying or Breast Feeding?	**Y**	**N**	Abnormal Wound Healing/Keloid Scars?	**Y**	**N**
Auto Immune Disorder?	**Y**	**N**	Eczema/Dermatitis/Psoriasis?	**Y**	**N**

Have you had any anti-wrinkle injections or fillers in the past? **Y** **N**

Anti-Wrinkle Date: _____ Treatment Area_____

Fillers Date: _____ Treatment Area_____

Have you had any IPL/Laser or Chemical Peels in the past? **Y** **N**

IPL/Laser Date: _____ Treatment Area_____

Chemical Peels Date: _____ Treatment Area_____

Skin Type-Fitzpatrick Measurement

Circle the number and description that best suits you.

Eye Colour	**0.**Light Colours	**1.**Blue,Gray,Green	**2.**Dark	**3.**Brown	**4.**Black
Natural Hair Colour	**0.**Sandy Red	**1.**Blonde	**2.**Chestnut or Dark Blonde	**3.**Brown	**4.**Black
Skin Colour-unexposed areas	**0.**Reddish	**1.**Pale	**2.**Beige or Olive	**3.**Brown	**4.**Dark Brown
Freckles-unexposed areas	**0.**Many	**1.**Several	**2.**Few	**3.**Rare	**4.**None
If you stay in the sun too long?	**0.**Painful Blisters/Peeling	**1.**Mild Blisters/Peeling	**2.**Burn, Mild Peeling	**3.**Rare	**4.**No Burning
Do you turn brown?	**0.**Never	**1.**Seldom	**2.**Sometimes	**3.**Often	**4.**Always
How brown do you get?	**0.**Never	**1.**Light Tan	**2.**Medium Tan	**3.**Dark Tan	**4.**Deep Dark
Is your face sensitive to the sun?	**0.**Very Sensitive	**1.**Sensitive	**2.**Sometimes	**3.**Resistant	**4.**Never have a problem
How often do you tan?	**0.**Never	**1.**Seldom	**2.**Sometimes	**3.**Often	**4.**Always
When was your last tan?	**0.**+3months ago	**1.**2-3months ago	**2.**1-2months ago	**3.**Weeks ago	**4.**Days ago
OFFICE USE ONLY					
SCORE TOTALS	:	:	:	:	:

TOTAL: _____ **0-6 Skin Type I** **7-13 Skin Type II** **14-20 Skin Type III** **21-27 Skin Type IV** **28-34 Skin Type V** **35+ Skin Type VI**

Country of Birth: _____ **Mother: _____** **Father: _____**

Skin Appearance

Are you suffering from active Acne?	**Y**	**N**	Do you experience dry flaky skin?	**Y**	**N**
Does your skin get excessively oily?	**Y**	**N**	Do you experience skin tightness?	**Y**	**N**
Do you suffer from Rosacea (constant flushing)?	**Y**	**N**	Do you have sun spots?	**Y**	**N**
Do you experience skin sensitivity?	**Y**	**N**	Do you have clusters of pigment?	**Y**	**N**

Home Care

Do you use a CLEANSER?	**Y**	**N**	MORNING NIGHT	Brand: _____
Do you use a TONER?	**Y**	**N**	MORNING NIGHT	Brand: _____
Do you use a MOISTURISER?	**Y**	**N**	MORNING NIGHT	Brand: _____
Do you use an EYE CREAM/SERUM?	**Y**	**N**	MORNING NIGHT	Brand: _____
Do you use a RETINOL OR VIT A?	**Y**	**N**	MORNING NIGHT	Brand: _____
Do you use a SPF?	**Y**	**N**		Brand: _____
Do you use any other products?	**Y**	**N**		

List: _____ _____

List: _____ _____

List: _____ _____

CONSENT

- In accordance with the *Privacy Act (1988),* all information collected in this practice is treated as "sensitive information". To protect your privacy, this practice operates in accordance with the Act.

Patient/Guardian Name:_____ Patient/Guardian Signature:_____Date: _____