CLINICAL NOTES – DO NOT TAKE AWAY

LINIA Skin Clinic

Surname:	Mr ☐ Mrs ☐ Miss ☐ Ms ☐
First Names:	Date of Birth:
Address:	Occupation:
	Known Allergies:
Telephone No:	Mobile No:
Email:	

PATIENTS TO COMPLETE

CONCERNS		TEREATMENT INTERESTED	
Acne/Blemishes		Laser hair removal	
Pigmentation		Skin peels	
Antiageing		Antiwrinkle and filler injections	
Rosacea/Sensitive skin		Skin tightening – eyes, face, jowls and neck	
Wrinkles and volume loss		Rejuvenation – Sunspots, pigmentation, wrinkles	
Woman's health		Plastic surgery	

You may be aware of the EU's General Data Protection Regulations (GDPR) which has come in to effect from 25th May 2018. This means you will have more accessibility to the data about you that is held by various companies, and better control over what they do with it. As part of this we need to confirm with you that you are happy for us to use your contact details via email. As I register and as per GDPR I opt in to be added to the database. If you wish not to opt in please inform us.

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WELCOME TO LINIA SKIN CLINIC

To enable us to better understand your needs can you please answer the following questions:

1. How did you hear about LINIA Skin Clinics? ……
2. What finally motivated you to seek advice/treatment? ……
3. What persuaded you to visit LINIA Skin Clinics? ……
4. What treatment(s) are you interested in? ……
   ……
5. How long have you been considering treatment? ……
6. What are your expectations from the treatment? ……
7. On a scale of 1 – 10 how much does your condition bother you? (please circle)
   1 being I am not bothered, 10 being I am very bothered by the condition. 1 2 3 4 5 6 7 8 9 10
8. Have you ever had any form of cosmetic treatment e.g. Fillers, Botox®, Eye Bag Removal, Nose Reshaping, Facelift(s), Skin Peels, Hair Removal or other Laser Treatments? If yes please give details
   ……
9. What are you doing at present to look after your skin? ……
10. What questions do you have? ……
    ……

MEDICAL HISTORY

1. Have you had any previous laser treatment? **Yes/No**
   If yes, what treatment did you have?……
2. Current condition requiring treatment and area of body to be treated: ……
   ……
3. Are you attending or receiving treatment from a doctor or specialist? **Yes/No**
   If yes, please give details: ……
4. Are you taking any medicine, pills, tablets, injections or any other drugs? **Yes/No**
   If yes, please give details: ……
5. Are you allergic to any medicines, antibiotics, food or other substances? **Yes/No**
   If yes please complete section on reverse.
6. Do you have any sensitivities to any products or chemicals? **Yes/No**
   If yes, please give details: ……
7. Have you ever suffered from or had any of the following illnesses/conditions?

a)	Psychiatric illness/depression	**Yes/No**	g) Diabetes	**Yes/No**
b)	Heart problems	**Yes/No**	h) Keloids	**Yes/No**
c)	Jaundice/hepatitis	**Yes/No**	i) Blood disorders	**Yes/No**
d)	Blackouts/Epilepsy – If yes, see below	**Yes/No**	j) Eczema/Psoriasis/Acne	**Yes/No**
	Is your epilepsy affected or caused by flashing light	**Yes/No**	k) Cold Sores	**Yes/No**
e)	Melasma (pigmentary changes of the face)	**Yes/No**		
f)	Vitiligo	**Yes/No**		

8. Are you currently pregnant **Yes/No** or breast-feeding **Yes/No**

Details of person to call in a medical emergency

Name:……Address:……
…….. Postcode: ……
Tel: ……Relationship: ……
G.P.Name:……Address:……
…….. Postcode: ……
Tel: …….. LINIA's policy is to contact your G.P. Please tick if you do not wish us to. ☐