# PRE-ASSESSMENT QUESTIONNAIRE

Name: Date:

How were you referred to our clinic?

☐ Friend ☐ Doctor Referral

______________________

☐ Word of mouth ☐ Staff member ______________________

☐ *Advertisement in* ___________________ ☐ *Mailer / Letter drop* ________________

☐ Clinic Website

☐ Other (Please Specify) _______________________________________________________

Would you like to receive special offers and updates on new treatments to your EMAIL only?
☐ YES ☐ NO

What is your Email?

## Medical Information

Do you have any allergies? ☐ yes ☐ no

If yes please describe

________________________________________________________________________________

Are you pregnant or breast feeding? ☐ yes ☐ no

Are you intending to become pregnant? ☐ yes ☐ no

Do you have any pre-existing or current medical conditions? ☐ yes ☐ no

Have you suffered from cold sores or keloid scarring? ☐ yes ☐ no

Do you have any currently active skin infection or acne? ☐ yes ☐ no

If yes please describe

____________________________________________________________________________________________

____________________________________________________________________ **Please Turn Over**


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Do you take any medication or supplements? ☐ yes ☐ no

If so please list

____________________________________________________________________

Have you undergone cosmetic treatments in the past? ☐ yes ☐ no

If so please list

____________________________________________________________________

____________________________________________________________________

Have there been any adverse reactions or disappointing outcomes from these treatments?

☐ yes ☐ no

If so please list

____________________________________________________________________

____________________________________________________________________

## Areas of Interest

(Please tick the areas you are interested in)

- ☐ Forehead lines
- ☐ Brow droop
- ☐ Dark circles under eyes
- ☐ Cheek enhancement
- ☐ Lip aging/ Thinning Lips
- ☐ Excessive sweating
- ☐ Downward turned mouth
- ☐ Lip lines
- ☐ Other (Please Specify)
- ☐ Crow’s feet
- ☐ Frown lines
- ☐ Neck aging
- ☐ Lower facial aging (eg. Jowls)
- ☐ Skin Texture & Quality
- ☐ Sun damage
- ☐ Lip enhancement
- ☐ Smile lines

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