PATIENT INFORMATION & CONSENT TO TREATMENT FORM

IT IS IMPORTANT THAT YOU UNDERSTAND AND ANSWER ALL THE QUESTIONS ON THIS QUESTIONNAIRE.
PLEASE DO NOT HESITATE TO ASK FOR ANY ASSISTANCE.

PERSONAL INFORMATION:

Title:................................Name:..Surname:..

Address:..

Date of Birth:..Country of Birth:..

Mobile:..Home Phone:..Work Phone:..

Email Address:..Occupation:..

Who can we contact in the unlikely event of an emergency:..

GP:..Phone & Address:..

Medicare Number:..Expiry:..Reference:..

Private Health:..Number: ....Level of cover:..

Are you Aboriginal or a Torres Strait Islander? Yes ☐ No ☐

Do you speak and understand English? Yes ☐ No ☐

If NO, do you need an interpreter? Yes ☐ No ☐

SKIN TYPE

Based on exposure to the summer sun, please tick the Skin Type which best describes our skin

☐ **Type I** Always burns, never tans
☐ **Type II** Always burns, sometimes tans
☐ **Type III** Sometimes burns, always tans
☐ **Type IV** Never burns, always tans
☐ **Type V** Moderately pigmented (Hispanic/Asian)
☐ **Type VI** Black

MEDICAL AND SURGICAL HISTORY			
Have you ever had an eating disorder or suffered anorexia	Y	N	
Do you have any allergies to medication, latex, tapes, lotions or foods	Y	N	Specify: Reaction:
Are you pregnant or Breastfeeding?	Y	N	Specify:
Do you smoke	Y	N	How many per day?
Have you ever smoked	Y	N	When did you stop?
Have you had any recent chest pains?	Y	N	Details:
Are you taking aspirin, blood thinning medication or anti-inflammatories, e.g. Nurofen?	Y	N	Which Medication? How often:
Are you taking any other medication? Including alternative medication and supplements.	Y	N	Specify:
Do you have depression or any psychiatric disorder, including Body Dysmorphic Disorder	Y	N	Specify: Medication:
Do you have intrusive thoughts regarding your body	Y	N	Specify:
Are you ever abused drugs or alcohol or been dependent on drugs or alcohol	Y	N	Specify:
Have you ever had an operation:	Y	N	Please list:
Do you have any Medical Conditions e.g. Thyroid	Y	N	Specify: Treatment:
Have you been in contact with someone who is MRSA, VRE or CRE Positive (Super Bugs)	Y	N	Specify:
Have you ever suffered from or been treated for MRSA, VRE or CRE Positive (Super Bugs)	Y	N	Specify:
Have you ever had fever, diarrhoea and / or vomiting in the last two (2) weeks?	Y	N	
Have you had a cold or any other infection in the last two (2) weeks?	Y	N	
HAVE YOU EXPERIENCED ANY OF THE FOLLOWING?			
Heart Conditions (Heart attack / Rheumatic Fever / Heart Murmur / Palpitations?	Y	N	Details:
High or low blood pressure?	Y	N	Details:
Blood clots in your lungs or legs?	Y	N	Details:
HIV, Hepatitis B, Hepatitis C	Y	N	Details:
Diabetes?	Y	N	How is it controlled?
Epilepsy?	Y	N	How is it controlled?
Facial Herpes Simplex?	Y	N	Details:
Asthma?	Y	N	Details:
Skin Disorders, such as psoriasis, eczema, dermatitis?	Y	N	Specify:
Major Eye Disorders E.g. Glaucoma?	Y	N	Specify:
Have you been admitted to hospital in the last 12 months	Y	N	Details:
If YES, was it outside WA?	Y	N	Details:
Do any family members have diabetes or heart disease	Y	N	Details:
Any other family illness	Y	N	Details:

COSMETIC PROCEDURE HISTORY			
Do you, or will you use, cosmetic blogs or forums?	Y	N	Details:
What surgical and/or non-surgical procedures are you interested in?			
Have you had previous surgical and / or non-surgical cosmetic procedures?	Y	N	
Did you have any complications?	Y	N	
Are you prone to fainting?	Y	N	
Have you been injected with Sculptra or Aquamid within the last three (3) years?	Y	N	
Do you or have you used, roaccutane, solariums or tanning creams?	Y	N	

Are you anxious about this consultation? Yes ☐ No ☐

Please select the reasons that apply:

☐ Complications / Side Effects ☐ Dissatisfaction with results ☐ Pain ☐ Previous Experience

☐ Other (Please specify):..

Daily, how often do you find yourself worrying about your appearance?

☐ Never ☐ Occasionally ☐ Frequently ☐ All the time

Please tick the statement that best describes your motivation for a cosmetic procedure (2 maximum)

☐ I want to appear slightly younger and refreshed

☐ I want to feel less self-conscious about my appearance

☐ I want to feel more confident in my personal and professional relationships

☐ I want to look significantly younger – e.g. Ten years younger

☐ I want to look completely different

☐ My appearance is one of my top priorities

☐ I want to correct a physical feature - please specify:...

☐ Other - please specify: ....

Why is it important for you bot have this procedure at this time in your life?

☐ I want to do it for myself

☐ I want to look the way I feel

☐ I am preparing for a milestone event (wedding, significant birthday etc.)

☐ I am dealing with life-changing events (divorce, bereavement, change in employment, relationship problems)

☐ I want to please my partner, friends, family

Please tick the emotion which best describes how you have felt over the past few weeks

☐ ☐ ☐ ☐ ☐

I acknowledge that the history I have given is complete and accurate. I agree to follow Absolute Cosmetic Doctor's and staff's instructions and treatment guidelines exactly and to report ANY problems or complaints immediately. I understand that complications may occur and these may incur a fee to treat and may lead to loss of time and income. I agree that the Absolute Cosmetic medical team are specifically experienced in cosmetic procedures and can assist in the treatment of complications and they will be my first point of contact. I also agree that I will be a realistic and responsible client and release all staff at Absolute Cosmetic from all liability. I will treat the staff at Absolute Cosmetic with courtesy and respect and I fully understand what I am signing.

Signature:...Date:..

HOW DID YOU HEAR ABOUT US?

Please be accurate and precise.

☐ Friend or Relative ☐ Facebook ☐ Twitter ☐ Street Sign ☐ Previous Patient
☐ Doctor: Name:..
☐ Beauty Salon: Which one:.. ☐ Magazine Advert: Which one:...
☐ Newspaper Advert ☐ Sunday Times ☐ West Australian ☐ Local Paper: ....
☐ Radio Advert: ☐ 94.5 ☐ 92.9 ☐ 96FM ☐ Nova ☐ Other: ....
☐ Google AdWords ☐ Google Search: Search Term Used:

☐ Friend or Relative ☐ Facebook ☐ Twitter ☐ Street Sign
☐ Previous Patient ☐ Doctor: Name:..
☐ Beauty Salon: Which one:.. ☐ Magazine Advert: Which one:...
☐ Newspaper Advert ☐ Sunday Times ☐ West Australian ☐ Local Paper: ....
☐ Radio Advert: ☐ 94.5 ☐ 92.9 ☐ 96FM ☐ Nova ☐ Other: ....
☐ Google AdWords ☐ Google Search: Search Term Used: ....
☐ Another online search engine: Search engine used: .... Search term: ....
☐ Yellow Pages ☐ Online ☐ Print Which section: ....
☐ Other – please specify: ....
Would you like to be added to our mailing list for new, events and specials? ☐ Yes ☐ No

Which form of contact would you prefer? *(You may unsubscribe at any time)*
☐ SMS ☐ Email ☐ Mail Out

Thank you for your assistance. We hope to make you a satisfied client. We are a full-time Cosmetic Medicine and Procedures Clinic (surgery to improve) and have over 15 years' experience with over 20,000 procedures performed. We do not perform Plastic Reconstructive Surgery (surgery to repair). I have been a Past Cosmetic Society President and am dedicated to the Cosmetic field.
My mobile number is freely available for contact. Please ask the staff for my card.
Regards,
DR. GLENN MURRAY

SEE DIAGRAMS BELOW – PLEASE MARK THE AREA/S OF YOUR BODY YOU WOULD LIKE IMPROVED UPON.