**Profhilo questionnaire and consent form**

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| --- | --- |
| Name: | Phone: |
| Address | Email: |
| **Previous medical condition or treatments** | **Yes / No** | **Details** |
| Cold sores? If yes, give details. |  |  |
| Jaundice, hepatitis, liver or kidney disease? |  |  |
| Asthma, Eczema or other allergic disease? |  |  |
| Any blood-borne diseases? |  |  |
| Angina, murmur, valve or other heart conditions? |  |  |
| A stroke or other blood pressure problems? |  |  |
| Neurological conditions, such as epilepsy, Bell’s Palsy, MS, Chorea or Myasthenia? |  |  |
| Allergic to latex, antibiotics, foods, drugs / substances? |  |  |
| Any recent vaccinations, cortisone injections or steroids? |  |  |
| Any other diseases, illnesses or treatments? |  |  |
| Have you ever had cancer? |  |  |
| **Current medical status** | **Yes / No** | **Details** |
| Are you receiving treatment from a doctor, hospital or specialist? |  |  |
| Do you carry a warning card, Epipen, had anaphylaxis reaction? |  |  |
| Are you taking medicines, pills, tablets, inhalers or using ointments? |  |  |
| Do you bruise or bleed easily? |  |  |
| Do you have any autoimmune disease, including Lupus? |  |  |
| Do you have any circulatory problems or varicose veins? |  |  |

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| **Current medical status continued** | **Yes / No** | **Details** |
| Do you have any endocrine disorders, such as diabetes or thyroid problems? |  |  |
| Do you follow a healthy diet? |  |  |
| Do you take regular exercise? |  |  |
| Do you have a good daily fluid intake? Please give details - what do you drink (water, tea, coffee alcohol) & how much. |  |  |
| Have you had electrical facial treatments before? |  |  |
| **Consent for marketing** |
| Photos may be taken before & after treatment. Do you consent for these to be used for marketing materials/ social media? |  |  |
| Do you consent to opting into receiving occasional promotional emails? |  |  |
| Do you consent to opting into receiving occasional marketing SMS/ text messages? |  |  |

I hereby certify that I have been fully informed of the nature and purpose of the procedure, its expected outcome and possible side effects. I understand that there is no guarantee or assurance as to the final result. I have been given the opportunity to ask questions and have fully read and understood the contents of this consent form. I have received an aftercare sheet and agree to follow the recommendations.

I consent to receiving \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. To the best of my knowledge, all of my answers are correct and I have not withheld any information that may be relevant to my treatment. I understand that photographs may be taken before and after treatments.

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| **Practitioner’s name and signature:** | **Client’s name and signature:** |

I consent to the use of topical anaesthetic cream.

**Client’s signature:**

I consent to the use of lidocaine (injected anaesthetic) products during treatment?

**Client’s signature:**