

COLLAGEN INDUCTION THERAPY MICRONEEDLING - MEDICAL HEALTH

Helen Thomas

AESTHETICS

beauty therapy and permanent cosmetics

Name: _____

Address: _____

Date of Birth: _____ Occupation: _____

Home Phone: _____ Work: _____

Mobile: _____ E Mail _____

Name of Doctor: _____

Surgery: _____

Have you consumed any aspirin, ibuprofen, alcohol in the last 72 hours? _____

Caffeine in the last 24 hours? _____

Have you had a dental injection to numb your mouth? _____

Are you pregnant or breastfeeding? _____

Do any of the following relate to yourself:

- | | | | | | |
|--------------------------|--------------------------|------------------------------|--------------------------|----------------------------|--------------------------|
| Allergies | <input type="checkbox"/> | Arthritis | <input type="checkbox"/> | Dermatitis | <input type="checkbox"/> |
| Blood pressure | <input type="checkbox"/> | Antidepressants | <input type="checkbox"/> | Rosacea | <input type="checkbox"/> |
| Blood thinning | <input type="checkbox"/> | Epilepsy | <input type="checkbox"/> | Acne | <input type="checkbox"/> |
| Bleeding disorders | <input type="checkbox"/> | Surgery (Cosmetic) | <input type="checkbox"/> | Fungal infections | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | Keloid scarring | <input type="checkbox"/> | Steroid therapies | <input type="checkbox"/> |
| Osteoporosis | <input type="checkbox"/> | Vitamin C Supplements | <input type="checkbox"/> | Chronic pain | <input type="checkbox"/> |
| Irregular menstruation | <input type="checkbox"/> | Sunbeds | <input type="checkbox"/> | Healthy sleep patterns | <input type="checkbox"/> |
| Menopausal | <input type="checkbox"/> | Major illness | <input type="checkbox"/> | Surgery | <input type="checkbox"/> |
| Superfluous hair problem | <input type="checkbox"/> | Heart condition | <input type="checkbox"/> | Implants | <input type="checkbox"/> |
| Polycystic ovaries | <input type="checkbox"/> | Bruise easily | <input type="checkbox"/> | Smoker | <input type="checkbox"/> |
| Psoriasis | <input type="checkbox"/> | Anaemia | <input type="checkbox"/> | Units of alcohol per week? | <input type="checkbox"/> |
| Eczema | <input type="checkbox"/> | Thyroid disorder | <input type="checkbox"/> | Caffeine, cups per day? | <input type="checkbox"/> |
| Hepatitis/HIV/Herpes | <input type="checkbox"/> | Poor absorption of nutrients | <input type="checkbox"/> | | |
| Lupus/ Vitiligo | <input type="checkbox"/> | Oral contraception | <input type="checkbox"/> | | |
| Immune system disorders | <input type="checkbox"/> | Endometriosis | <input type="checkbox"/> | | |

Sunburn history

Tanning ability

List any medications or supplements (especially vit C, vit D, Omega 3 & 6) _____