AVANA CLINIC CONSULTATION FORM

Please complete the following information to maximise the effectiveness of the treatment and ensure your safety. Please answer all questions and sign below. All information given is treated as confidential.

Name:	D.O.B:	Male □ Female □
Address:		
Postcode:	Suburb:	
Phone: (Home)	Mobile:	
Email:		
GP Name and Address:		

Please read carefully and answer each section

(the more we know about your health the better we can service your needs)

1. Tick any of the following allergies that apply:

□ Lanolin □ Latex Gloves □ Medical Tape □ Novocaine/Lindocaine □ Paints

□ Metals □ Food □ Medications □ Crayons □ Hair Dyes

□ Other allergies:

2. Tick any of the following that apply:

□ Glaucoma □ Contact lenses □ Conjunctivitis (pink eye) □ Cataracts

□ Dry Eyes □ Alopecia □ Blurred Vision □ Eye Makeup sensitivities □ Trichotillomania (pull out eyelashes and brows compulsively)

Eyebrow tinting - Date of last service?

Eyelash tinting - Date of last service?

Other Eye Disorders/Conditions?

When was the last time you visited a dentist?

□ Chapped lips □ Cold Sores (acyclovir) □ Herpes □ Ulcer

Are you taking medication for any of the mouth /lips conditions above? □ YES □ NO

3. List any medications you have been taking in the past 6 months:

4. Have you had any Injectable treatments in the past 2 years: □ YES □ NO

□ Collagen Injections □ Botox □ Dermal Fillers

Please name the anti-aging filler (eg.fat transfer injections):

Name the area which has been filled (eg.lips, cheeks, eyes, forehead etc):

What was the date these treatments were performed?

5. Please tick all of the following that apply:

Have you received Chemotherapy in the past year?	□ YES	□ NO
Have you had semi-permanent make up before?	□ YES	□ NO
Any other tattoos? Age of the tattoo/s	□ YES	□ NO
Do you have a Piercings? Where?	□ YES	□ NO
Use of a tanning bed, suntan outdoors?	□ YES	□ NO
Are currently tanned in the area to be treated?	□ YES	□ NO
Currently using ***Retin A / Roaccutane*** or other skin thinning lotions or creams?	□ YES	□ NO
Currently using Glycolic Acid or other AHA/BHA products?	□ YES	□ NO
Have you had a Chemical Peel / CO2 Laser / ND Yag Laser / IPL?	□ YES	□ NO
Do you have a scar you want softened/camouflaged?	□ YES	□ NO
Any keloid or hypertrophic scars?	□ YES	□ NO
Cancer/Luekemia (within the last 3 years)	□ YES	□ NO
*If **YES** please describe and name the treatments:*		
Skin Cancers:	□ YES	□ NO
*If **YES** please describe and name the treatments:*		
Recent surgeries in the last 12 months:	□ YES	□ NO
*If **YES** please describe and name the treatments:*		
Future surgery?	□ YES	□ NO
*If **YES** please describe and name the treatments:*		
Are you currently pregnant or trying? Breast feeding or nursing?	□ YES	□ NO

6. Have you ever had or currently have one of the following:

□ Bruise or Bleed Easy
□ Healing Problem
□ Irregular Periods
□ Thyroid Abnormalities
□ Dermatitis
□ Active Acne
□ Pigmentation
□ Rosacea
□ Anemia
□ Fainting or Dizziness Spells
□ Alopecia
□ Sensitivity to Cosmetics
□ Liver Disease
□ Do you smoke? □ Yes □ No
□ High Blood Pressure
□ Asthma/Breathing Difficulty
□ Currently on Blood Thinners
□ Hemophilia or other Clotting Disorders
□ Metal Parts in the Body. Where?
□ Seizures
□ HIV □ Yes □ No
□ Contraceptive Pills
□ Pregnancy / Breast Feeding

□ Prolonged Bleeding
□ Polycystic Ovaries
□ Diabetes
□ Eczema
□ Psoriasis
□ Cystic Acne
□ Moles/Warts/Skin Tags
□ Sunburn in treatment area
□ Trichotillomania
□ Circulatory Problems
□ Keloid Scaring
□ Tumors, Growths or Cysts
□ Heart palpitations/Conditions
□ Epilepsy
□ Low Blood Pressure
□ Uncontrolled Diabetes or Diabetes
□ Anxiety/Stress/Nervousness
□ Mitral Valve Prolapse or Valve Implants
□ Taken **Roaccutane** in the last 6 months
□ Auto Immune Disorders
□ Hepatitis □ A □ B □ C
□ Blood Transfusion

7. If under a physician's care for any condition, please describe:

Please list any medications, prescription and non-prescription, that you may have taken in the last 2 weeks:

8. This history form has been read, understood and signed herein, and all of my questions in regard to my treatment have been answered satisfactorily. I am over 18 years of age, and if not have presented a parental name and authorization signature below to perform the treatment. I understand and have had explained to me proper home care treatment for my procedure. I understand that these procedures may produce some swelling, redness, itching, discomfort, numbness and adverse side effects. I understand that the treatment I have chosen is for cosmetic purposes only and no guarantees have been made to me concerning the results of the procedure. I understand that the results achieved, and number of treatments required will differ from person to person.

I do * /do not * give consent to allow photographs of me taken to be kept under my file.

Client's Name: **Client's Signature:** **Date:**

Practitioner's Name: **Practitioner's Signature:** **Date:**

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Date	Treatment	Note