ACNE SCAR REVISION
CONSULTATION CARD

Dundrum Cosmetic Clinic "Invest in yourself"

PERSONAL DETAILS			
Full Name		**Date**	
Occupation		**Home Telephone number**	
Date of Birth		**Email**	
Mobile		**General Practitioner's (GP) Details**	
Address		**Dr Name:**	
Town/City		**Address:**	
Eircode		**Contact Number:**	

How did you hear about us?

Have you read our pre-treatment information pack that we have sent via email?

YES NO

For further discounts, do you want to join our loyalty scheme?

YES NO

If so, how would you like to be contacted?

TEXT EMAIL BOTH

PLEASE NOTE: We do not pass your confidential information onto any third parties.

MEDICAL HISTORY

Are you currently receiving medical treatment? **YES** **NO**

DETAILS:

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MEDICAL CONDITIONS	Please TICK any of the following that applies to you		
Photo-Sensitive Epilepsy		Thrombosis/Phlebitis (blood clots)	
Photo-Sensitive Migraines		Low Blood Pressure	
Cancer or History of Cancer		Are you prone to fainting spells	
Auto Immune Disease		Hyper-Sensitive Skin	
HIV+Blood		Vitiligo	
Any type of Hepatitis		Chloasma/Melasma	
Heart/Cardiac Disorders		Varying Skin Pigmentation	
Pacemaker/Internal Metal Pins		Skin Infections	
Thyroid Therapy		Skin Conditions e.g. psoriasis, eczema	
Kidney Disease		Skin Allergies:	
Asthma		E.g. to rubber gloves	
Depression/Anxiety		to Aloe Vera	
Lupus		to Tea Tree	
Diabetes		Other allergies	
Shingles (within the last 6 months)		Moles on Treatment Area	
Keloid Scarring		Herpes Simplex/Cold Sores	
Recent Surgery		Deep Fillings/Crowns	
Poor Wound Healing		Others	

MEDICINES & SUPPLEMENTS

Roaccutane
Antibiotics
Have you recently taken Antibiotics?
YES NO
St John's Wort
Iron Supplements
Gold Injections
Cancer Treatment/Medication

Steroids
Have you recently taken Steroids?
YES NO
Hormone Therapy
Mood Stabilizers Anti-Depressants Other:

LIFESTYLE

Smoker
Alcohol Consumption
(within the last 24 hours)

Recent Sun/ UV Exposure
Botox/Fillers
(within the last 4 weeks)

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WOMEN ONLY		N/A
Pregnant Breastfeeding Hormone Replacement Therapy Contraceptive Pill Irregular Menstrual Cycle		Polycystic Ovarian Syndrome Endometriosis Hormone Imbalance Hirsutism Hypertrichosis

SKIN TYPE & UV EXPOSURE

Have you sunbathed or used a sunbed during the past 4 weeks? (Please specify when)

Are you planning a sun holiday or planning to use sunbeds during the next year? (Please specify when)

How does your skin respond to sun exposure?

Always burns, never tans Always burns, sometimes tans Sometimes burns, always tans Never burns, always tans

SKIN HISTORY

Please complete the appropriate section only

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What area/s do you wish to treatment? **FACE** **BODY**

Details:

What are your concerns with your skin?

Have you had any Laser or IPL treatment performed in the past? **YES** **NO**

Details:

Have you had any other cosmetic skin treatments? **YES** **NO**

Details:

Do you apply sunscreen or a product containing sun protection daily? **YES** **NO**

Regular Skincare brands and products used:

Morning:

Evening:

Occasional: