**Patient Consultation Data Sheet**

|  |  |
| --- | --- |
| **Full Name (** [ ]  **Miss /** [ ]  **Mrs /** [ ]  **Mr )** Click here | **Date of Birth (D)** 00 **(M)** 00 **(Y)** 0000 **Age:** 00 **y.o.** |
| **E-mail** Click here |
| **Address** Click here | **Phone No.** Click here |
| **Mobile No.** Click here |
| **Occupation**Click here  | **Nationality**Click here | **Weight**Click here | **Height**Click here | **Blood Type**Click here |

**Please fill-in the blanks or check your most appropriate response:**

1. What major symptom(s) or problem(s) brought you in for consultation?

 Click here to enter text.

2. When did you start having the symptom(s)?

 Click here to enter text.

3. Has it been treated previously? [ ]  YES [ ] NO

4. Have you undergone any type of surgery (including cosmetic surgery)? [ ]  YES [ ]  NO

5. Have you undergone any type of anesthesia (i.e.: Topical, Local, General, Dental)? [ ]  YES [ ]  NO

* If YES, did you experience any adverse effects from the anesthesia? [ ]  YES [ ]  NO
	+ - If YES, which symptom(s) describe what happened?

[ ]  Itchiness

[ ]  Nausea

[ ]  Sudden drop / increase in blood-pressure

[ ]  Dizziness

[ ]  Difficulty in breathing

[ ]  Chest tightness/pain

[ ]  Swelling

[ ]  Others: \_\_\_\_\_\_\_\_\_\_\_\_

6. Do you have a history of any previous medication-related allergy? [ ]  YES [ ]  NO

* If YES, kindly provide the necessary details (ie: drug/medicine name and allergic reaction)

[ ]  Penicillin

[ ]  NSAIDS (Ibuprofen, Mefenamic Acid, etc)

[ ]  Pyrines

[ ]  Aspirin

[ ]  Unrecalled antibiotics

[ ]  Others: \_\_\_\_\_\_\_\_\_\_\_\_

7. Do you have any other allergies? [ ]  YES [ ]  NO

* If YES, kindly check all that apply

[ ]  Pollen

[ ]  Bronchial Asthma

[ ]  Atopic Dermatitis (Skin Allergy)

[ ]  Allergic Rhinitis

[ ]  Allergic Conjunctivitis

[ ]  Seafood

[ ]  Nuts

[ ]  Others: \_\_\_\_\_\_\_\_\_\_\_\_

8. Does your skin form Keloid scars after wound healing? [ ]  YES [ ]  NO

9. Do you have any metallic implants (pace maker, artificial joints, plates, etc) in your body? [ ]  YES [ ]  NO

10. Do you have any subdermal implants of gold thread or any metallic implants in your face? [ ]  YES [ ]  NO

11. Do you have any metallic dental implants / amalgams or teeth capping? [ ]  YES [ ]  NO

12. Are you currently taking any prescription medication(s) or supplement(s)? [ ]  YES [ ]  NO

* If YES, kindly specify Click here

(Questions 13 – 15 are for Female patients only)

13. When was the first day of your last menstrual period? (D) 00 (M) 00 (Y) 0000 (No. days) 00

14. Are you currently pregnant? [ ]  YES [ ]  NO

 Do you have plans to get pregnant in the future? [ ]  YES [ ]  NO

 Are you currently breastfeeding? [ ]  YES [ ]  NO

15. Have you been pregnant and given birth? [ ]  YES [ ]  NO

* If YES, at what age? ( 00 years old)
* If YES, which method? [ ]  Normal Spontaneous Delivery [ ]  Cesarean Section
* If YES, did you breastfeed? [ ]  YES [ ]  NO

16. Have you undergone any form of physical examination within the past 6 months? [ ]  YES [ ]  NO

* If YES, was further medical evaluation or additional tests recommended? [ ]  YES [ ]  NO

17. Have you ever been diagnosed with any major health problem or pre-existing medical condition in the past?

 [ ]  YES [ ]  NO

* If YES, kindly check all that apply

[ ]  Cardiovascular (High blood-pressure | Angina | Heart disease/CVD | Others: Click here)

[ ]  CNS & HEENT (Encephalitis or Meningitis | Stroke/CVA | Hyperhidrosis | Tonsillitis | Others: Click here)

[ ]  Pulmonary (Bronchial Asthma | COPD | Pneumonia | Tuberculosis | Others: Click here)

[ ]  Gastro-Intestinal (Peptic Ulcer | GERD | Hyperacidity | Stomach cancer | Others: Click here)

[ ]  Hepatobiliary ( Liver infection or Hepatitis | Gallstones | Fatty liver | Others: Click here)

[ ]  Reproductive (Myoma | Ovarian cysts | Hormonal imbalance | Others: Click here)

[ ]  Breast (Breast cancer | Mastitis | Breast Cyst or benign tumor | Others: Click here)

[ ]  Musculoskeletal (Osteopososis | Scoliosis | Others: Click here)

[ ]  Endocrine & Rheumatic (Diabetes Mellitus | Thyroid disease | Lupus | Rheumatoid Arthritis | Gout | Others: Click here)

[ ]  Other diseases: Click here

* If you have encircled any of the items above, are you still receiving treatment for said condition?

[ ]  YES [ ]  NO

18. Have you ever received any blood transfusion? [ ]  YES [ ]  NO

19. Do you currently have any infectious or communicable disease? [ ]  YES [ ]  NO

20. Do you exercise, play any sports, or are physically active? [ ]  YES [ ]  NO

21. Do you wear sunscreen? [ ]  YES [ ]  NO

* If YES, SPF 000, PA 000

22. Which of the following cosmetics do you use? (Please specify the brand)

[ ]  Facial Wash: Click here

[ ]  Body soap: Click here

[ ]  Lotion: Click here

[ ]  Moisturizer / Serum: Click here

[ ]  Toner: Click here

[ ]  Cream: Click here

[ ]  Emulsion: Click here

[ ]  Foundation: Click here

[ ]  Powder: Click here

[ ]  Shampoo: Click here

[ ]  Conditioner / Rinse: Click here

[ ]  Others: Click here

* Are you currently using any cosmetics that contain Retinoic Acid, Tretinoin, Isotretinoin, Glycolic Acid, or Salicylic Acid? [ ]  YES [ ]  NO
* Are you currently receiving treatments from other clinics involving personal care regimens that require applying Acid (ex: Proactiv, Skin Peeling, Gommage Exfoliation, etc)? [ ]  YES [ ]  NO

23. Do you have any other concerns apart from today’s consultation? [ ]  YES [ ]  NO

* If YES, kindly check all that apply

[ ]  Body odor

[ ]  Excessive sweating or

Hyperhidrosis

[ ]  Laser hair removal

[ ]  Hair growth for Balding

[ ]  Age spots

[ ]  Freckles

[ ]  Wrinkles

[ ]  Acne and Acne scars

[ ]  Large pores

[ ]  Broken spider capillaries

 [ ]  Mole removal

[ ]  Birthmarks

[ ]  Scar removal (ex: Keloid)

[ ]  Sagging / Loose skin

[ ]  Laser face lift

[ ]  Skin rejuvenation and

Revitalizing Injections

[ ]  Skin Whitening

[ ]  Glutathione + Vit. C IV

[ ]  Body Contour & Slimming

[ ]  Cellulite treatment

[ ]  Dermatological counselling

[ ]  Others: Click here

24. Would you like to join our mailing list for exclusive promos, special campaigns, and updates? [ ]  YES [ ]  NO

* If YES, which mailing method(s) would you prefer? (Check all that apply)

[ ]  Direct Mail (Monthly Newsletter)

[ ]  E-mail (Monthly Newsletter)

25. How did you get to know about Azabu Skin Clinic?

[ ]  Friend / Family / Officemate Referral

[ ]  Magazine Ad ( [ ]  EURObiz [ ]  Tokyo Metropolis [ ]  iNTOUCH [ ]  Philippine Digest )

[ ]  Online Website

* + ( [ ]  PC [ ]  Mobile )
	+ ( [ ]  Banner Ad [ ]  Google Search [ ]  Yahoo search [ ]  Safari [ ]  Facebook

 [ ]  Others: \_\_\_\_\_\_\_\_\_\_)

* + - if through searching, what key words did you use? Click here to enter text.

[ ]  Others: Click here