**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