Medical history form template for aesthetics clinics

[Clinic name] medical history and visit update form

Form version: [date]

Please answer the questions below and tell us if you are unsure. Ask the practitioner for help with anything you do not understand. Do not change or stop any medicine because of this form.

Privacy information: [link or supplied document reference]

Patient details

Full name: _____

Date of birth: _____

Patient record reference: _____

Telephone / preferred contact method: _____

Email, if used for care communications: _____

Address: _____

Communication, accessibility or support needs: _____

Healthcare contacts

GP or usual healthcare provider / practice: _____

Contact details, if known: _____

Relevant specialist or current care team: _____

Emergency contact, where appropriate: _____

Any discussion about contacting another healthcare professional, including the information proposed to be shared: _____

Health history

Are you currently receiving medical care or awaiting an investigation or procedure? Yes / No / Unsure

Details: _____

Do you have any long-term health conditions or a significant medical or surgical history? Yes / No / Unsure

Details and dates, where known:
_____

Please tell us about relevant conditions or experiences, including any of the following. These questions collect information for review and do not decide eligibility for treatment.

Question	Yes / No / Unsure	Details or discussion needed
Heart or blood pressure condition		
Diabetes or another metabolic condition		
Neurological or neuromuscular condition, including seizures		
Bleeding or clotting condition		
Autoimmune condition or treatment affecting the immune system		
Skin condition, infection or wound in the proposed treatment area		

Question	Yes / No / Unsure	Details or discussion needed
Cold sores or previous relevant infection		
Scarring or wound-healing concerns		
Fainting, needle anxiety or support needed during procedures		
Other information relevant to the planned consultation		

Medicines and supplements

List prescribed medicines, over-the-counter medicines and supplements, including dose if known. Include recent changes and anything you have recently stopped. The practitioner may ask for further detail.

Medicine / supplement	Dose, if known	Reason for use	Recent change / date

Are you unsure of any medicine name or dose? Yes / No

Information to check before a treatment decision: _____

Allergies and previous reactions

Do you have any known allergy or previous reaction to a medicine, local anaesthetic, injectable product, latex, adhesive or other substance? Yes / No / Unsure

Substance / product, if known	Reaction and date	Medical assessment or treatment received

History of a severe allergic reaction: Yes / No / Unsure

Details: _____

Previous aesthetic treatment

Have you had aesthetic treatment before? Yes / No / Unsure

Treatment / product, if known	Area	Approximate date	Relevant reaction or follow-up

Details of any complication, ongoing concern or treatment by another practitioner:
_____

Current circumstances

Are you pregnant, breastfeeding or planning pregnancy? Yes / No / Prefer to discuss

Do you have a recent or planned medical, dental or other procedure the practitioner should know about? Yes / No / Unsure

Details: _____

Other relevant changes to health or circumstances: _____

Patient declaration

I have answered to the best of my knowledge and identified anything I am unsure about. I will tell the clinic about changes to my health, medicines or circumstances before a future treatment. I understand that the practitioner will review my answers with me; this form does not itself confirm suitability or give consent to treatment.

Patient name and signature: _____

Date: _____

Assistance or interpreter used, if applicable: _____

Practitioner review

History reviewed with the patient on: _____

Positive, uncertain or incomplete answers discussed: _____

Further information, advice or referral needed and who will obtain it: _____

Assessment / treatment decision and rationale recorded separately at:
_____

Practitioner name, registration where applicable and signature: _____

Date and time: _____

Update at a later visit

Visit date: _____

Changes to health, medicines, allergies, pregnancy status or previous treatment since the last review:
_____

Patient confirmation: _____

Practitioner review, action and linked assessment reference: _____

Reviewer name, signature and date: _____