

10:20 AMWed 22 Apr

CancelFacial Consultation

What's your name?

First name

First name

Last name

Last name

Email address (optional)

SMS Number (+64) (optional)

Date of birth (optional)

Tap here to select a date

What changes are you hoping to see in your skin? (optional)

Answer

Do you have concerns about any of the following? (optional)

☐ Discolouration

☐ Acne scarring

☐ Uneven texture

☐ Fine lines and wrinkles

☐ Enlarged pores

☐ Loss of facial contours

☐ Oily skin

☐ Dilated capillaries

☐ Lax or sagging skin

☐ Acne/breakouts

☐ Redness

☐ Dark under eye circles

What sort of skin do you think you have?

☐ Dry

☐ Normal

☐ Combination

☐ Oily

Do you have a history of acne?

☐ Yes

☐ No

Do you use Retin A?

☐ Yes

☐ No

Have you ever used Accutane?

☐ Yes

☐ No

Do you use glycolic acid products?

☐ Yes

☐ No

Have you ever had an acid peel?

☐ Yes

☐ No

Are you claustrophobic?

☐ Yes

☐ No

Do you wear contact lenses?

☐ Yes

☐ No

Do you sunbathe or use tanning beds?

☐ Yes

☐ No

Please list any allergies (optional)

Answer

Please list any health conditions that could affect your treatment (optional)

Answer

I confirm that the information I have given is correct to the best of my knowledge.

Please sign in the box above

Clear

Complete