SKIN **REVIVE :::**

The real alternati ve to surgery

Patient Consultation & Order Form

Please send us this signed document by scan to info@skin-revive.com or the original format to our clinic based on No10 Harley Street, London W1G 9PF or simply fax the signed document to 020 7467 8312

COSMECEUTICALS
(Please enter the name, quantity and listed price of the prescription strength product(s) you wish to purchase)

Products	Strength	Qty	Price

PERSONAL INFORMATION

Name (please print clearly)

Address

Post code Country

Phone

E-mail

Occupation

EMERGENCY CONTACT

Secondary contact

Relationship to you Phone number

GP's Name

GP Surgery Name

GP Surgery Address

Phone

HEALTH QUESTIONNAIRE
(if you have any of the following please circle the appropriate condition)

Anaemia	Bleed Easily	Cancer or Tumour	Diabetes
Dark skin spots	Heavy scarring	Eye or vision problems	Liver disease or hepatitis
Phlebitis	Stomach ulcer	Skin lesion, moles	Dermatitis
Eczema	Keloids	Epilepsy	Acne
Spider veins	Joints problem	Angina	Heart disease
HIV	High blood pressure	Herpes	Asthma

IF ANSWERED YES TO ANY OF THE CONDITION LISTED PLEASE GIVE DETAILS

MEDICATION, HERBAL YOU ARE TAKING
(Please only list the medications you are taking)

Example:	Benzoyl peroxide	Scrubs	Salycylic acid (aspine, ibuprofene)
Skin lighteners	Glycolic acid	Accutane	Retin A
Antibiotics	Fertility treatments	Oral contraceptive	Vitamins

IF ANSWERED YES TO ANY OF THE CONDITION LISTED PLEASE GIVE DETAILS (Why? dosage and frequency)

PAST MEDICAL HISTORY (Please circle the most appropriate option)				IF ANSWERED YES TO ANY OF THE CONDITION LISTED PLEASE GIVE DETAILS
Surgery	Chronic illnesses	Diabetes	Asthma	
Bronchitis	TB	Rheumatic fever	High blood Pressure	
Heart disease	Kidney disease	Liver disease	Epilepsy	
Stroke	Skin lesion removed	Ulcer	Low blood pressure	

ALLERGIES
(List all medicine allergies – all medicines you are allergic to or have had reactions of any kind)

List of medicines:

List of any substance :

Have you ever had an excessive allergic reaction?
IF YES (give details)

GENERAL
(Please answer the following questions)

Are you pregnant?
Are you breast feeding?
Do you smoke? How many?
Do you drink alcohol? How much?
Do you take recreational drugs?

SKIN TYPE
(Please circle the most appropriate option)

What colour are your eyes?	Light blue, or gray or green	Blue, gray, or green	Blue	Dark brown	Brownish black
What is the natural colour of your hair?	Sandy red	Blond	Chestnut or dark blonde	Dark brown	Black
What colour is your skin?	Reddish	Very pale	Pale with beige tint	Light brown	Dark brown
Do you have freckles?	Many	Several	Few	Incidental	None

MY APPEARANCE CONCERNS
(Please circle the most appropriate option)

Wrinkles	Nose
Eyes – bags under / droopy eye lids / dark circles	Jowling
Facial scarring / Acne scars	Uneven texture / Hyper pigmentation
Large pores	Thin lips
Facial hair	Spider veins
Excessive sweating	Other

Patient Authorization (Please Check)

I am over the age of majority, and:

1. I have fully and accurately disclosed my personal information and health information and consent to its use by a Medical Doctor at Skin Revive. I am not seeing my General Practitioner (GP) or my Dermatologist for any health problems.
2. I understand that all products in the prescription shall be sold & dispensed by Skin Revive operating within a unique international jurisdiction and in a manner consistent with the laws of that jurisdiction.
3. I authorise and appoint Medical Doctors at Skin Revive to review my consultation form and decide whether I should receive of prescription for the product I have ordered. This authorisation shall include, but not be limited to collecting and using my personal health information as reasonably necessary for the fulfilment of my order, including disclosure to a licensed doctor if required for the assistance in provide the most appropriate step in relation to the delivery of my prescription. I am also aware that regardless the doctors decision the consultation fees are not refundable.
4. I understand that although a doctor can prescribe a prescription strength product without talking to me face-to-face, I may face higher risks related to the proper use of the product based on my health condition and personal profile.

I HAVE READ AND UNDERSTAND THESE TERMS AND AGREE THAT SHALL BE BINDING ME AND MY ASSIGNS, HEIRS AND PERSONAL REPRESENTATIVES.

Patient's Signature_____/_____/_____/
Date (MM/DD/YY)