

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) | IF ANSWERED YES TO ANY OF THE CONDITION LISTED PLEASE GIVE DETAILS | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|------------------------|---------------------------------------|---------------------------------------|-----------------|----------------|------------------------|----------------------------|-------------|----------------------|--------------------|------------|--------|---------|----------|-------|--------------|----------------|--------|---------------|-----|---------------------|--------|--------|--|
| <table border="0"> <tr> <td>Anaemia</td> <td>Bleed Easily</td> <td>Cancer or Tumour</td> <td>Diabetes</td> </tr> <tr> <td>Dark skin spots</td> <td>Heavy scarring</td> <td>Eye or vision problems</td> <td>Liver disease or hepatitis</td> </tr> <tr> <td>Phlebitis</td> <td>Stomach ulcer</td> <td>Skin lesion, moles</td> <td>Dermatitis</td> </tr> <tr> <td>Eczema</td> <td>Keloids</td> <td>Epilepsy</td> <td>Acne</td> </tr> <tr> <td>Spider veins</td> <td>Joints problem</td> <td>Angina</td> <td>Heart disease</td> </tr> <tr> <td>HIV</td> <td>High blood pressure</td> <td>Herpes</td> <td>Asthma</td> </tr> </table> | 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 | |
| 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 | | | | | | | | | | | | | | | | | | | | | | |
| MEDICATION, HERBAL YOU ARE TAKING (Please only list the medications you are taking) | IF ANSWERED YES TO ANY OF THE CONDITION LISTED PLEASE GIVE DETAILS (Why? dosage and frequency) | | | | | | | | | | | | | | | | | | | | | | | | |
| <table border="0"> <tr> <td><i>Example:</i></td> <td>Benzoyl peroxide</td> <td>Scrubs</td> <td>Salicylic acid (aspirine, ibuprofene)</td> </tr> <tr> <td>Skin lighteners</td> <td>Glycolic acid</td> <td>Accutane</td> <td>Retin A</td> </tr> <tr> <td>Antibiotics</td> <td>Fertility treatments</td> <td>Oral contraceptive</td> <td>Vitamins</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </table> | <i>Example:</i> | Benzoyl peroxide | Scrubs | Salicylic acid (aspirine, ibuprofene) | Skin lighteners | Glycolic acid | Accutane | Retin A | Antibiotics | Fertility treatments | Oral contraceptive | Vitamins | _____ | _____ | _____ | _____ | | | | | | | | | |
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| Skin lighteners | Glycolic acid | Accutane | Retin A | | | | | | | | | | | | | | | | | | | | | | |
| Antibiotics | Fertility treatments | Oral contraceptive | Vitamins | | | | | | | | | | | | | | | | | | | | | | |
| _____ | _____ | _____ | _____ | | | | | | | | | | | | | | | | | | | | | | |

| 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:

- 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.
- 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.
- 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.
- 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)