



Patient record: Dermato-aesthetics

Blank form to fill in by hand.

Clinic

Doctor

Date

____ / ____ / ____
dd/mm/yyyy

Essentials

First name

Last name

Date of birth

____ / ____ / ____
dd/mm/yyyy

Place of birth

Nationality

Profession

Phone number

Email

Address

Gender

☐ Female ☐ Male ☐ Non binary ☐ Prefer not to say

1. Skin Assessment

Fitzpatrick skin type

- ☐ Always burns, never tans
☐ Usually burns, tans minimally
☐ Sometimes burns, tans gradually
☐ Rarely burns, tans easily
☐ Very rarely burns, tans darkly
☐ Never burns, deeply pigmented

Skin type

☐ Normal ☐ Dry ☐ Oily ☐ Combination ☐ Sensitive

Primary concern

2. Medical History

Allergies?

☐ Yes ☐ No

If yes, give details:

Autoimmune conditions?

☐ Yes ☐ No

If yes, give details:

Keloid or scarring tendency?

☐ Yes ☐ No

If yes, give details:

Active or recurrent cold sores?

☐ Yes ☐ No

If yes, give details:

Isotretinoin in the last 6 months?

☐ Yes ☐ No

If yes, give details:

Pregnant or breastfeeding?

☐ Yes ☐ No

If yes, give details:

Previous aesthetic treatments

3. Photographic Documentation

Before treatment

Space for a photo or sketch

Before photo date

/

/

dd/mm/yyyy

After treatment

Space for a photo or sketch

After photo date

/

/

dd/mm/yyyy

4. Consent

Aesthetic procedure consent

1. I have been informed in an understandable way about my diagnosis, the purpose of the proposed treatment, the procedures that may be performed, reasonable alternatives, expected benefits, limitations and possible risks.

2. I have been informed that the outcome of treatment cannot be guaranteed absolutely and that additional procedures, check-ups or treatment may be needed depending on the clinical situation.

3. I have had the opportunity to ask questions, and I declare that the answers I received were sufficient for my decision.

4. I authorize the aesthetic practitioner and clinical staff to perform the agreed treatment and clinically necessary supporting procedures within the treatment plan discussed with me.

5. I have been informed that I have the right to refuse the treatment or to withdraw this consent at any time. Withdrawal does not affect procedures performed before it.

Patient or Legal Representative Signature

Doctor Signature

Date:

Date:

5. Treatment Record

Products and treated areas

Date	Product	Batch no.	Treated area	Amount

Reactions and follow-up

Next treatment due

Signature

Date

/

/

dd/mm/yyyy