haley brooke

Treatment History Form

Patient Information

Given Name/s	
Surname	
Date of Birth	

Known Allergies

Please provide a list of any known allergies or allergic reactions to treatments you may have, or experienced. If none please write 'NIL'

Medications

Please provide a list of the medications you are currently taking. If none please write 'NIL'	
Antibiotics:	
Anticoagulants:	
Other: (Roaccutane)	

Treatment History

Please provide a list of your treatment history. This may include any treatments completed by Haley in the past or by any other clinic you have been to. If none please write 'NIL'

Chronic Conditions

Please provide a list of any relevant chronic conditions. If none please write 'NIL'

Information Accuracy Statement

I have filled out this form to the best of my knowledge and understand that providing incorrect information may lead to delays in treatments/ outcomes.
☐ Please tick if you understand and agree with the above statement.

Client or Guardian Signature	
Date:	