CLIENT HEALTH AND SAFETY FORM - EYE TREATMENT

Name	
Date of Birth	
Address	
Telephone	
Mobile	
Email	
Have you had eye treatments previously **YES/NO**	If you answered Yes to the previous question Please give details
Have you experienced any reaction to any substance used on your eyes **YES/NO**	If you answered Yes to the previous question please give details
Last visit to the Doctor	
Doctor's Address	

Contraindications requiring medical permission – in circumstances where medical permission cannot be obtained clients must give their informed consent in writing prior to treatment (select if/where appropriate)

Medical oedema	☐	Epilepsy	☐	Nervous/Psychotic conditions	☐
Recent Diabetes	☐	Skin Cancer	☐	Facial operations affecting the area	☐
Whiplash	☐	Undiagnosed pain	☐	When taking prescription medication	☐
Slipped disc	☐				

Contraindications that restrict treatment (select if/where appropriate)

Hypersensitive skin	☐	Botox /dermal fillers (2 weeks following treatment)	☐		
Hyper-keratosis	☐	Skin allergies	☐	Styes	☐
Watery eyes	☐	Inflamed nerve	☐	Eye infection	☐
Conjunctivitis	☐	Fever	☐	Diarrhoea/vomiting	☐
Any known Allergies	☐	Localised bruising	☐	Inflammation	☐
Cuts	☐	Bruises	☐	Abrasions	☐
Sunburn	☐	Eczema	☐	Sinusitis	☐
Neuralgia	☐	Migraine/Headache	☐	Hormonal Implants	☐
Undiagnosed lumps	☐	Recent Fractures (Minimum 3 months)	☐		
Contagious or infectious diseases	☐	Trapped/pinched nerve affecting the treatment area	☐		
Under the influence of recreational drugs or alcohol	☐				
Scar tissues (2 years for major operation and 6 months for a small scar)	☐				

Details on ticked areas above

Print and Sign Name	
Date	