Health questionnaire

The Oasis Rooms wishes to provide not only the highest quality of service, but also the safest possible conditions for you to receive your treatment. For us to maintain this standard we need to be aware of any existing medical conditions or medications you may have taken or are currently taking. **This information is held strictly confidential under the Data Protection Act (1998).**

CLIENT DETAILS

Full Name: .... D.O.B. ....

Address: .... Postcode: ....

Tel No. .... Mobile No. ....

How did you hear about us? Internet ☐ Word of Mouth ☐ Walk in ☐ Gift Voucher ☐

Promotion ☐ Advertising ☐ Other (Please state)...

Email : ....@...

Would you like to receive our monthly email newsletter? Yes ☐ No ☐

Doctor's Name: .... Tel No ....

Medical History ....

Do you have any medical conditions? Yes ☐ No ☐

If yes, please provide details of all current medical conditions (e.g. asthma, cancer, diabetes, epilepsy, heart condition, back pain, arthritis etc)

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Do you suffer any known allergies ? Yes ☐ No ☐

If yes, please state what allergies (e.g. medication, nuts, dust, plants etc) ....

Do you suffer from high or low blood pressure? Yes ☐ No ☐

Are you pregnant or believe you might be within the first 12 weeks of pregnancy? Yes ☐ No ☐

If yes, you will be unable to have any form of massage and should you have any reason to be concerned then we recommend that you do not have your treatment.

Have you undergone any surgery in the last 6 months? Yes ☐ No ☐

If yes, please provide details..

Please provide details of any medication you are currently taking and disclose what that medication is used for (e.g. medicated acne treatment, retin – A, chemotherapy, antibiotics)

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Have you had a Spa treatment/massage before? Yes ☐ No ☐ If yes, how long ago? ....

Do you have any difficulty lying on your back front or side? Yes ☐ No ☐

Do you have any infectious skin conditions eg athletes foot, verruccas, warts? Yes ☐ No ☐

If yes, please provide details ....

To avoid the possibility of there being any contra-indications arising from the treatment(s) you are having with us, it is important that you fully disclose now and in the future (by completing a new form if necessary) any such medical information. Always consult your doctor first about any concerns you may have about your health. In certain cases written permission will be required either by your GP/Specialist prior to any treatments being conducted. I confirm that I have not withheld any information regarding any medical conditions or problems that I may be experiencing and that I have provided details of all the medications I am currently taking.

Signed.. Date ....

Patch Test Disclaimer
For health and safety regulations patch testing is required 24 hours prior to the following treatments: Tinting and Eyelash perming. Upon refusal of a patch test please read and sign the following disclaimer: I accept personal liability for any adverse reactions (e.g. burning, skin irritation, allergic reaction etc) that may occur as a result of the product used due to refusing the required patch test.

Signed.. Date ....