healthXchange Group	Doc. No.: FORM HXP5	Rev. No.: 0
Devices Patient Clinical Query Form	Date:	Page: 1 of 2

Treating Physician Name:	Account Code:
Clinic Name & Address:	
Physician Email:	Contact Number:
Patient Name:	
Date of Birth:	Contact Number:
Address:	
☐ Email:	Male ☐ Female ☐

	Skin Type 1 2 3 4 5 6	Date of Treatment:	Procedure explained and consent forms signed: ☐ Yes ☐ No

Event or Product Concern

Date Patient Treated:	Before & After Photos Attached: Yes No

Type of Problem or Event (tick any that apply):

- ☐ Required medical or surgical intervention to prevent permanent damage/impairment
- ☐ Prolonged side effects including: (Please tick)
- ☐ Itchy
- ☐ Stinging
- ☐ Swelling

  Please indicate how long you have experienced these: _____

- ☐ Other

  Please specify: _____

Equipment/ Device used for treatment?

Prescribed Equipment Protocols and any changes made to these protocols. Please also enter levels used and any skin preparation:

Description of event/ problem (attach separate sheet if needed)

Any other treatments undertaken during treatment:

Spa treatments Laser Hair Removal/Waxing/Plucking/Threading Massage

Other:

Patients Medical History including existing conditions (including any use of supplements/rescue remedies):

Signature of Patient: Date:

Signature of Physician: Date:

Signing consents to Healthxchange Pharmacy Ltd being able to contact the treating physician if required to assist with further investigations. If you do not wish for this to happen, please tick here ☐