Obagi Patient Clinical Query Form	Doc. No.: FORM HXP5	Rev. No.: 0
	Date:	

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

Patch Test at time of Purchase: ☐ Yes ☐ No	Skin Type 1 2 3 4 5 6	Date Regime Started:	The Patient was shown protocols and signed a consent form as part of the Obagi treatment ☐ Yes ☐ No

Event or Product Concern

Date Patient Reviewed:	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: ____

Describe event or problem: (may attach separately)

Product in Use or Recommended?

Prescribed Protocols and any changes made to these protocols (ie any changes to frequency, dose or percentage of Tretinoin) and date of these changes:

State Review periods: ____/____/_____ ____/____/____ ____/____/____ ____/____/____

Any association with household pets? Yes No

Any other products incorporated into the regime OR removed from the regime during use? (personal items or add-ons)

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):

(You may be asked to Supply the buying trend of the patient during use of all products to assess more closely the concerns)

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 ☐