

REPORT FORM FOR ADVERSE REACTIONS AS THE RESULT OF THE USE OF A COSMETIC

Report date: / /20

Please keep the cosmetic(s) concerned by the unwanted effect for at least 3 months.

<p><u>SENDER</u> Name, surname: Profession : doctor, pharmacist, dentist other (clarify) : Address : Tel : E-mail :</p>	<p><u>User:</u> Initials : Age : Sex : <input type="checkbox"/> F <input type="checkbox"/> M Profession :</p>
<p><u>Description of the adverse reaction:</u></p>	<p><u>PRODUCT/INGREDIENT</u> Batch Nr: Complete Name Company, brand Function of the product: Place of purchase: Data of the manufacturer as mentioned on the label:</p>
<p><u>Place of the adverse reaction:</u> On the place where the product was used: <input type="checkbox"/> yes Distant reaction: <input type="checkbox"/> yes Describe the concerned areas:</p>	<p><u>Treatment</u> <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> locally <input type="checkbox"/> general Type of treatment: <u>Evolution of the symptoms</u> <input type="checkbox"/>recovery: <input type="checkbox"/>completely healed <input type="checkbox"/>healing <input type="checkbox"/>no healing <input type="checkbox"/>hospitalisation</p>
<p><u>Use of the product:</u> Date of first use: / /20 Frequency of use (per day/week/month): Duration use of product: Date appearance adverse reaction: / /20 Simultaneous use of other products (other cosmetics, medication, food supplements, ...):</p>	<p><u>History</u> - Allergy (which): - Skin disorders (which): - Other disorders (which):</p>
<p><u>Use conditions</u> <input type="checkbox"/>Professional use <input type="checkbox"/>Normal use <input type="checkbox"/>Wrong use</p>	<p><u>Remarks</u></p>

Data in bold are obligatory. Filled in data will be treated confidentially.