patient profile

Name:_____ DOB:_____ Age:_____ Sex:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone:_____ E-mail:_____

About You:

- What is your hereditary background? (circle all that apply) Nordic / Scandinavian / Irish / English / Asian / Mediterranean / Hispanic / Native American / Middle Eastern / African American / Other _____
- Natural eye color: _____
- Natural hair color: _____
- Do you consider your skin (circle the best option): Sensitive / Resilient / Unsure
- Describe your skin (circle all the apply): Normal / Dry / T-Zone/Combination / Thick / Thin / Saggy / Firm / Oily / Acne / Comedones/Blackheads / Milia / Cysts / Breakouts / Acne-scarred / Large pores / Small pores / Rosacea / Eczema / Freckled / Sun-damaged / Melasma / Hyperpigmentation / Hypopigmentation / Uneven/Blotchy / Mature / Wrinkled / Patchy dryness / Sallow / Psoriasis / Dehydrated/Lacking moisture / Asphyxiated / Telangiectasia/Broken surface capillaries
- What are the changes you'd most like to see in your skin?

_____

_____

_____

Lifestyle:

- Are you pregnant or lactating? ❑ No ❑ Yes
  (**Please consult with your obstetrician.** Only the Oxygenating Trio®, Detox Gel Deep Pore Treatment or Hydrate: Therapeutic Oat Milk Mask are appropriate.)
- Do you wear contact lenses? ❑ No ❑ Yes
  (**Remove contacts** if eyes are sensitive or if having microdermabrasion.)
- Do you currently have a sunburned/windburned/red face? ❑ No ❑ Yes
  Why? _____
- Are you in the habit of going to tanning booths? ❑ No ❑ Yes
  (If within past 14 days, decline treatment. This practice should be discontinued due to increased risk of skin cancer and signs of aging.)
- Do you participate in vigorous aerobic activity or sports? ❑ No ❑ Yes
  What type? _____
- Do you smoke or use tobacco? ❑ No ❑ Yes
- What kind of work do you do? _____
- On average, how many hours per week do you spend outdoors? _____

Medical/Treatment History:

- Do you currently use depillatories or wax? ❑ No ❑ Yes
  (Discontinue use five days pre- and post-treatment.)
- Have you had a chemical peel or any type of procedure with a medical device? ❑ No ❑ Yes
  Within the last 14 days? ❑ No ❑ Yes
  What type? _____
- Do you have regular collagen, Botox® or other dermal filler injections? ❑ No ❑ Yes
  (Peels should precede or follow injections by two days to prevent movement of the filler or stinging at the injection site.)
- Have you recently had laser resurfacing or facial surgery? ❑ No ❑ Yes
  Describe _____
  When? _____
- Are you currently taking any medications, topical or otherwise? ❑ No ❑ Yes
  (Tretinoin/Retin-A®/Renova®/Differin®/Tazorac®/Avage®/ EpiDuo™/Ziana®)
  Which one(s)? _____
  For how long? _____
  What strength? _____
  (High percentages of certain ingredients may increase sensitivity. Discontinue use five days before and after treatment. Consult your physician before discontinuing use of any prescription.)
- Are you currently using any topical retinoid prescriptions? ❑ No ❑ Yes
- Have you ever undergone Accutane® therapy (isotretinoin)? ❑ No ❑ Yes
  (**If you are currently using Accutane® therapy (isotretinoin), please consult with your dispensing physician.**)
  (If you are no longer using Accutane® therapy (isotretinoin) it is OK to apply ONE layer of Ultra Peel® I, Sensi Peel,® Ultra Peel® II, Esthetique Peel, Oxy Trio,® Hydrate: Therapeutic Oat Milk Mask or Revitalize: Therapeutic Papaya Mask.)
- Do you develop cold sores/fever blisters? ❑ No ❑ Yes
  Last breakout? _____
- Are you allergic/sensitive to (circle all that apply) milk / apples / citrus / grapes / aloe vera / aspirin / perfumes / latex / hydroquinone / mushrooms?
  If any other allergies, what? _____
- Have you ever used any other products that caused a bad reaction? ❑ No ❑ Yes
  Describe _____

Patient Signature:_____Date:_____

Clinician Signature:_____Date:_____

consent form

Prior to receiving treatment, I have been candid in revealing any condition that may have bearing on this procedure, such as: pregnancy (if so, consult your physician prior to treatment), recent facial surgery, allergies, tendency to cold sores/fever blisters, or use of topical and/or oral prescription medications such as: tretinoin, Retin-A®, isotretinoin, Accutane®, Differin®, Tazorac®, Avage®, EpiDuo™ or Ziana®.

I understand there may be some degree of discomfort such as stinging, pin-prickling sensation, heat or tightness.

I understand there are no guarantees as to the results of this treatment, due to many variables, such as: age, condition of skin, sun damage, smoking, climate, etc.

I understand I may or may not actually peel and that each case is individual. I understand that the amount of peeling does not correlate with degree of improvement.

I understand this treatment is a cosmetic treatment and that no medical claims are expressed or implied.

I understand that to achieve maximum results, I may need several treatments.

I understand that although complications are very rare, sometimes they may occur and that prompt treatment is necessary. In the event of any complications, I will immediately contact the physician/clinician who performed the treatment.

I agree to refrain from tanning in tanning beds or outdoors while I am undergoing treatment, and during the 14 days prior to and following the end of treatment. This practice should be discontinued due to the increased risk of skin cancer and signs of aging.

I understand that extended direct sun exposure is prohibited while I am undergoing treatment, and the daily use of sunscreen protection with a minimum SPF of 30 is mandatory.

I have not had any other chemical peel of any kind within 14 days of this treatment. I understand I cannot have another chemical peel within 14 days of this treatment, whether it is performed at this location or any other location.

I understand that I should follow my clinician's recommendations for post-procedure skin care to minimize side effects and maximize results.

I hereby agree to all of the above and agree to have this treatment performed on me. I further agree to follow all post-peel care instructions as I am directed.

Signature: ________________________________Date:________

Initials: ___________

Signature of Clinician: __________________________________

Signature of Witness:___________________________________

Continued Treatment Consent

Date	Initials