patient profile

Name:_____ DOB:_____Age:_____Sex: _____
Address:_____
City:_____State:_____Zip:_____Phone: _____

- Are you pregnant or lactating? Yes___No___**(Please consult with your obstetrician. Only the Oxygenating Trio or Detox Gel is appropriate.)**
- Do you wear contact lenses? Yes___No___(**Remove contacts** if eyes are sensitive or if having microdermabrasion)
- Do you have permanent makeup? Yes___No___(If so, to what areas of the face?) _____
- Do you currently have a sunburn/windburn/red face? Yes___No___Why? _____
- Are you in the habit of going to tanning booths? Yes___No___(If within past three weeks, decline treatment)
- Do you currently use or receive dipilatories or waxing? Yes___No___(Discontinue use 7 days pre and post treatment)
- Are you applying any topical medications at this time? Yes___No___ Which one(s)? _____ (High percentages of certain ingredients may increase sensitivity)
- Are you currently using any topical Retinoid prescriptions (Retin-A®/Renova®/Differin®/Tazorac®/Avage®?) Yes___No___What strength?_____For how long?_____(discontinue use 5-7 days before and after treatment) Consult your physician before discontinuing use of any prescription.
- Are you currently using Accutane®? Yes___No___How long?_____It is OK to apply ONE layer of Ultra Peel® I, Sensi Peel®, Ultra Peel® II, Esthetique Peel™ or Oxy Trio to skin that has been treated with Accutane®. **Those who are currently taking Accutane® should be directed to their dispensing physician.**
- Have you had a chemical peel or any type of procedure with a medical device? Yes___No___ Within the last 14 days? Yes___No___
- Do you have regular collagen, Botox® or other dermal filler injections? Yes ___No___(Peels should follow injections by 2-5 days to prevent movement of the filler)
- Have you recently had facial surgery? Yes___No___Describe:_____How long ago? _____
- Have you recently had laser resurfacing? Yes ___No___When?_____ What kind?_____
- What type of work do you do?_____Regular airline travel? Yes___No___How often?_____
- Do you participate in vigorous aerobic activity or sports? Yes___No ___What type? _____
- Do you smoke or use tobacco? Yes ___No___
- Do you develop cold sores/fever blisters? Yes___No___ Last breakout? _____
- Are you allergic/sensitive to? (Check all that apply) milk ___ apples___ citrus ___ grapes___ aloe vera___ aspirin ___ perfumes___ latex___ hydroquinone___ mushrooms___ If any other allergies, what?_____
- Are you sensitive to alcohol-based products? Yes___No___
- Have you ever used any other products that caused a bad reaction? Yes___No___Describe_____
- Are you taking any medication at this time? (antibiotics may increase sensitivity) _____
- What is your hereditary background? _____
  Natural eye color: Blue ___ Green___ Hazel___ Gray___ Lt. Brown___ Med. Brown___ Dk. Brown___
  Natural hair color: Blond___ Red___ Lt. Brown___ Med. Brown___ Dk. Brown___ Black___ Gray/Silver___ White ___
  Skin tone: Pale/White___ Light ___ Medium___ Reddish___ Freckled___ Sallow___ Lt. Olive ___ Med. Olive___
  Dark Olive___ Lt. Brown ___ Med. Brown___ Dark Brown___ Soft Black___ Black___
- Do you consider your skin: Sensitive___ Resilient___ Unsure?___
- Describe your skin (check all that apply): Thick___ Thin___ Saggy___ Firm___ Normal___ Dry___ T-Zone/Combination___ Oily___ Acne___ Comedones/Blackheads___ Milia___ Cysts___ Breakouts___ Acne-scarred___ Large pores___ Small pores___ Florid___ Rosacea___ Eczema___ Freckled___ Sun-damaged___ Uneven/blotchy___ Mature___ Wrinkled___ Patchy dryness___ Sallow___ Melasma___ Perfume-stained___ Hypopigmentation___ Psoriasis___ Hyperpigmentation___ Dehydrated/lacking moisture___ Asphyxiated___Telangiectasia/broken surface capillaries ___
  What is your daily care regimen? _____
  _____
- What are the cosmetic improvements you would like to see in your skin? _____

Treatment recommendation: _____
Patch test: Date_____Solution_____Test Area_____Result_____
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, use of Retin-A®, Accutane®, Differin®, Tazorac® or Avage®.

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, that each case is individual. 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 doctor/clinician who performed the treatment.

I agree to refrain from tanning in tanning booths or outdoors while I am undergoing treatment, and during the 14 days following the end of treatment.

I understand that extended direct sun exposure is prohibited while I am undergoing treatment, and the daily use of sunscreen protection with a minimum of SPF 15 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 treatment within 14 days of this treatment, whether it is performed at this location or any other location.

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