Patient Profile-Peel

Name:_____Email Address:_____
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 deep pore treatment 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 use or receive dipilatories or waxing? Yes___No___(Discontinue use five days pre- and post-treatment.)
• 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 14 days, decline treatment; we recommend this practice is discontinued altogether.)
• 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 (trentinoin/Retin-A®/Renova®/Differin®/Tazorac®/Avage®/ EpiDuo™/Ziana®)? Yes___No___What strength?_____For how long?_____(Discontinue use 5 days before and after treatment. Consult your physician before discontinuing use of any prescription.)
• Are you currently using Accutane®? Yes___No___For 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___ What type? _____
• Do you have regular collagen, Botox® or other dermal filler injections? Yes ___No___(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 facial surgery? Yes___No___Describe:_____How long ago?_____
• Have you recently had laser resurfacing? Yes ___No___When?_____ What type?_____
• 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):** Normal___ Dry___ T-Zone/Combination___ Thick___ Thin___ Saggy___ Firm___ _Oily___ Acne___ Comedones/Blackheads___ Milia___ Cysts___ Breakouts___ Acne-scarred___ Large pores____ Small pores___ Florid___ Rosacea___ Eczema___ Freckled___ Sun-damaged___ Melasma____ Hyperpigmentation___ Perfume-stained___ Hypopigmentation___ Uneven/blotchy___ Mature____ Wrinkled___ Patchy dryness___ Sallow___ Psoriasis____ Dehydrated/lacking moisture___ Asphyxiated___ Telangiectasia/broken surface capillaries ____

Patient Signature:_____Date:_____

Clinician Signature:_____Date:_____