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 depilatories 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? ❑ No ❑ Yes
  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:_____