

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 _____	

