

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.)
- 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, Oxygenating 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 / No Yes
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: _____