

Name: _____ DOB: _____ Age: _____ Sex: _____

Address: _____ SS#: _____

City: _____ State: _____ Zip: _____

Phone: _____ Cell Phone: _____

E-mail: _____ May we send you information by email: _____ Yes _____ No

Patient/ Parent's Employer: _____ Work Phone: _____

For privacy purposes how do you prefer to be contacted: Phone __ Home __ Cell __ Work __ E-Mail __ Text

Marital Status: _____ Married _____ Single _____ Divorced _____ Separated _____ Widow _____ Partner

About You:

- What is your hereditary background? (check all that apply)

<input type="radio"/> Nordic	<input type="radio"/> Irish	<input type="radio"/> Hispanic	<input type="radio"/> Mediterranean
<input type="radio"/> English	<input type="radio"/> African American	<input type="radio"/> Asian	<input type="radio"/> Middle Eastern
<input type="radio"/> Native American	<input type="radio"/> Scandinavian	Other _____	

• Natural eye color: _____

• Natural hair color: _____

Do you consider your skin (check the best option):

- Sensitive Resilient Unsure

• Describe your skin (check all that apply):

- | | | | | | | |
|---|-----------------------------|------------------------------------|--|--------------------------------------|--|---------------------------------|
| <input type="radio"/> Normal | <input type="radio"/> Dry | <input type="radio"/> Freckled | <input type="radio"/> Psoriasis | <input type="radio"/> Sun-damaged | <input type="radio"/> Saggy | <input type="radio"/> Firm |
| <input type="radio"/> Oily | <input type="radio"/> Acne | <input type="radio"/> Acne-scarred | <input type="radio"/> Breakouts | <input type="radio"/> Mature | <input type="radio"/> Wrinkled | <input type="radio"/> Psoriasis |
| <input type="radio"/> Thin | <input type="radio"/> Thick | <input type="radio"/> Small pores | <input type="radio"/> Large pores | <input type="radio"/> Asphyxiated | <input type="radio"/> Eczema | <input type="radio"/> Rosacea |
| <input type="radio"/> Sallow | <input type="radio"/> Cysts | <input type="radio"/> Milia | <input type="radio"/> Melasma | <input type="radio"/> Patchy dryness | <input type="radio"/> Uneven/Blotchy | |
| <input type="radio"/> Dehydrated/Lacking moisture | | | <input type="radio"/> Hyperpigmentation | | <input type="radio"/> Hypopigmentation | |
| <input type="radio"/> Comedones/Blackheads | | | <input type="radio"/> T-Zone/Combination | | | |

Telangiectasia/Broken surface capillaries

• What are the changes you'd most like to see in your skin?

Lifestyle:

- Are you pregnant or lactating? o No o 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? o No o Yes
 (Remove contacts if eyes are sensitive or if having microdermabrasion.)
- Do you currently have a sunburned/windburned/red face? o No o Yes
 Why? _____
- Are you in the habit of going to tanning booths? o No o 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? o No o Yes
 What type? _____
- Do you smoke or use tobacco? o No o 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? o No o Yes
(Discontinue use five days pre- and post-treatment.)
- Have you had a chemical peel or any type of procedure with a medical device? o No o Yes
Within the last 14 days? o No o Yes
What type? _____
- Do you have regular collagen, Botox® or other dermal filler injections? o No o 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? o No o Yes
Describe _____
When? _____
- Are you currently taking any medications, topical or otherwise? o No o 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? o No o Yes
- Have you ever undergone Accutane® therapy (isotretinoin)? o No o 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? o No o Yes
Last breakout? _____
- Are you allergic/sensitive to (check all that apply) o No o Yes
o milk o apples o citrus o grapes o aloe vera
o aspirin o perfumes o latex o hydroquinone o mushrooms?
If any other allergies, what? _____
- Have you ever used any other products that caused a bad reaction? o No o Yes
Describe _____

How were you referred to us: _____

Emergency Contact: _____ Relationship: _____

Phone Number: _____

Patient Signature: _____ Date: _____

Clinician Signature: _____ Date: _____