

Patient profile

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

Address: _____

City: _____

State: _____ Zip: _____ Phone: _____

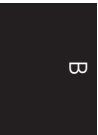
E-mail: _____

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): 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 / None of the above Other _____
- What are the changes you'd most like to see in your skin?

Lifestyle:

- Are you pregnant or lactating? (Please consult with your obstetrician) No Yes
- Do you wear contact lenses? No Yes
(Remove contacts if eyes are sensitive or if receiving microdermabrasion.)
- Do you currently have a sunburned/windburned/red face? No Yes
(If so, a professional peel is not recommended. The **Hydrate: Therapeutic Oat Milk Mask** is an excellent option to help soothe and heal inflamed skin.)
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 professional 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, neurotoxin (i.e. Botox®), or other dermal filler injections? No Yes
 (If so, ask your clinician what daily care correctives or professional treatments can help support these injections.)
- Have you recently had laser resurfacing or facial surgery? No Yes
 Please 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) and you have checked with your physician, it is OK to apply ONE layer of No Peel Peel, Sensi Peel, Advanced Treatment Booster, 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 / 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: _____