MICRODERMABRASION AND PEEL

patient profile

Name:________________________________ DOB:______________Age:____Sex: __________
Address:____
City:______________State:______Zip:______Phone:______________E-mail:________________

- Are you pregnant or lactating? Yes___No___**(Please consult with your obstetrician. Only the Oxygenating Trio® or Detox Gel Deep Pore Treatment 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 use or receive depilatories or waxing? Yes___No___(Discontinue use five days pre- and post-treatment.)
- 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 14 days, decline treatment. This practice should be discontinued due to increased risk of skin cancer and signs of aging.)
- 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 (tretinoin/Retin-A®/isotretinoin/Accutane®/Renova®/Differin®/Tazorac®/Avage®/EpiDuo™/Ziana®)? Yes___No___What strength?__________For how long?__________ (Discontinue use five days before and after treatment. Consult your physician before discontinuing use of any prescription.)
- Are you currently undergoing isotretinoin therapy (Accutane®)? Yes___No___For 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 undergoing isotretinoin therapy (Accutane®)). **Those who are currently undergoing isotretinoin therapy (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___ What type? ________
- Do you have regular collagen, Botox® or other dermal filler injections? Yes ___No___(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 facial surgery? Yes___No___Describe:________________How long ago? __________
- Have you recently had laser resurfacing? Yes ___No___When?____________ What type?__________
- 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): Normal___ Dry___ T-Zone/Combination___ Thick___ Thin___ Saggy___ Firm___ Oily___ Acne___ Comedones/Blackheads___ Milia___ Cysts___ Breakouts___ Acne-scarred___ Large pores___ Small pores___ Florid___ Rosacea___ Eczema___ Freckled___ Sun-damaged___ Melasma___ Hyperpigmentation___ Perfume-stained___ 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?________________

Patient Signature:____________________Date:______________

Clinician Signature:____________________Date:______________

consent form

Prior to receiving treatment, I have been candid in revealing any condition that may have bearing on this procedure, such as: pregnancy (if so, consult your physician prior to treatment), recent facial surgery, allergies, tendency to cold sores/fever blisters, or use of topical and/or oral prescription medications such as: tretinoin, Retin-A®, isotretinoin, Accutane®, Differin®, Tazorac®, Avage®, EpiDuo™ or Ziana®.

I understand there may be some degree of discomfort such as stinging, pin-prickling sensation, heat or tightness.

I understand there are no guarantees as to the results of this treatment, due to many variables, such as: age, condition of skin, sun damage, smoking, climate, etc.

I understand I may or may not actually peel and that each case is individual. I understand that the amount of peeling does not correlate with degree of improvement.

I understand this treatment is a cosmetic treatment and that no medical claims are expressed or implied.

I understand that to achieve maximum results, I may need several treatments.

I understand that although complications are very rare, sometimes they may occur and that prompt treatment is necessary. In the event of any complications, I will immediately contact the physician/clinician who performed the treatment.

I agree to refrain from tanning in tanning beds or outdoors while I am undergoing treatment and during the 14 days, prior to and following the end of treatment. This practice should be discontinued due to the increased risk of skin cancer and signs of aging.

I understand that extended direct sun exposure is prohibited while I am undergoing treatment, and the daily use of sunscreen protection with a minimum of SPF 30 is mandatory.

I have not had any other chemical peel of any kind within 14 days of this treatment. I understand I cannot have another chemical peel within 14 days of this treatment, whether it is performed at this location or any other location.

I understand that I should follow my clinician's recommendations for post-procedure skin care to minimize side effects and maximize results.

I hereby agree to all of the above and agree to have this treatment performed on me. I further agree to follow all post-peel care instructions as I am directed.

Signature: ______________________________ Date: _______

Initials: __________

Signature of Clinician: ______________________________

Continued Treatment Consent

Date	Initials