SKIN CARE HISTORY QUESTIONNAIRE

Please answer the following questions so that I may have a better understanding of your general health and lifestyle, thereby enabling me to accurately analyze and assess your skin-care needs.

Name *(please print clearly)*

Date ____/____/____

Date of Birth

____/____/____

First Last M.I.

Street Address

City **State** **Zip Code**

Text

Home Phone **E-Mail Address**

( )

Please check if presently using any of the following. *(please ✓ all that apply)*

❑ Accutane ❑ Glycolic Acid/Alpha Hydroxy Acid ❑ Topical Vitamin C
❑ Hydroquinone ❑ Retinoid (Vitamin A derivatives) i.e. Retin A, Renova, Differin

Which conditions do you want to improve *(please ✓ all that apply)*

❑ Hyperpigmentation (Brown Spots) ❑ Acne/Acne Scarring ❑ Sun Damage ❑ Enlarged Pores
❑ Fine Lines & Wrinkles ❑ Age Spots ❑ Surgical Facial Scars ❑ Other: _____

Have you ever had an allergic reaction to any skin product or cosmetic? ❑ Yes ❑ No

FEMALE CLIENTS

Are you on hormone-replacement therapy? ❑ Yes ❑ No
Are you presently taking birth control pills? ❑ Yes ❑ No
Are you pregnant or planning to be? ❑ Yes ❑ No

ALL CLIENTS

Do you use a sunscreen/sunblock? ❑ Yes ❑ No
Do you sunbathe or participate in outdoor activities? ❑ Yes ❑ No

Do you have or have you ever had acne? ❑ Yes ❑ No
Are you using or have you ever used any medications for acne? ❑ Yes ❑ No
Name of medication _____

Have you seen a dermatologist in the past year? ❑ Yes ❑ No
If yes, list doctor's name and reason for visit _____

Are you presently under a doctor's care? ❑ Yes ❑ No
What medications do you take on a regular basis? _____

Have you ever had herpes (cold sores)? ❑ Yes ❑ No
Have you ever been treated with Zovirax or any medication for herpes? ❑ Yes ❑ No

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Do you have epilepsy or diabetes? ❑ Yes ❑ No
If yes, you will be treated only with a doctor's release!

Do you use Biore, Snore Strips, or any other Medical Apparatuses? ❑ Yes ❑ No

Have you had any of the following? ❑ Yes ❑ No *(please ✓ all that apply)*
❑ Cosmetic Surgery ❑ Botox Injections ❑ Skin Cancer ❑ Dermatitis ❑ Keloid Scarring
❑ Laser Resurfacing ❑ Chemical Peels ❑ Hepatitis ❑ Other (Specify) _____

Are you allergic to aspirin? ❑ Yes ❑ No Are you allergic to iodine or seaweed? ❑ Yes ❑ No
Do you have any other allergies? ❑ Yes ❑ No
If yes, list: _____

Do you smoke?	❑ Yes	❑ No
Do you take nutritional supplements?	❑ Yes	❑ No
Are you on a diet?	❑ Yes	❑ No
Do you exercise?	❑ Yes	❑ No
Do you wear contact lenses?	❑ Yes	❑ No
Have you had skin treatments (facials) before?	❑ Yes	❑ No
Are you currently having facials?	❑ Yes	❑ No
Have you had electrolysis or waxing in the past week?	❑ Yes	❑ No
Do you have those services done regularly?	❑ Yes	❑ No
Have you had permanent cosmetics?	❑ Yes	❑ No

If yes, where? _____

How is your general health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

What skin-care products are you currently using? _____

What is it about your skin you would like to change? _____

Is there any other information I should know before beginning your treatment? _____

Client Signature

SKIN REJUVENATION
INFORMED CONSENT

Please read and initial after each paragraph.

You have the right to be informed about your skin peeling treatment.

	INITIAL HERE
I have been given the Skin History Questionnaire and have read and answered the questions thoroughly. I have discussed any further questions that I may have with my skin care specialist.	
I am aware and acknowledge that there is a rare possibility of an allergic reaction. I have discussed thoroughly with my skin care specialist any such reactions and understand them. I have had a patch test and it is negative.	
I am willing to forego a patch test, but understand there could be an allergic response.	
I have been advised that my treatment is a noninvasive, light epidermal exfoliation consisting of any of the following: salicylic acid, AHAs, retinol, TCA, resorcinol, or red wine vinegar acid.	
These are superficial procedures. The use of the above ingredients stimulates the skin to generate new skin cells and new collagen formation and increases the blood circulation and flow to the skin. It does not replace deep chemical peels, laser resurfacing or plastic surgery.	
I acknowledge that during application I will notice a warm sensation and the skin may tingle, sting or burn. Immediately after the peel my face may appear frosted or sunburned, and by day two, the skin may darken in color, feel tighter, and be more sensitive. Days two through seven, the skin will peel. I am not to pick or peel the old skin. Pulling or picking skin may lead to infection (which will require treatment with topical antibiotic) or surface scarring. I may experience some breaking out after a peel.	
I acknowledge that I will avoid direct sun exposure and tanning beds during this procedure and will apply a sunscreen daily.	
Skin peels may lighten hyperpigmented skin, and I acknowledge that there is NO GUARANTEE that dark discoloration of the skin known as melasma will be reduced or faded. I am aware that there could even be an increase of uneven color from this procedure.	
I acknowledge that I have not been on Accutane during the past six months.	
I acknowledge that I have not been using Retin A or Renova for the past two weeks.	
I acknowledge that if I am prone to cold sores (herpes), I may need a prescription from my physician prior to having the peel. I am aware the treatment could bring about cold sores.	
I acknowledge that I am not aspirin-sensitive or, if I am, I have discussed this with my skin care specialist and understand that there could be a reaction.	
I acknowledge that I will not have any other skin care procedures of any sort until I am passed by my skin care specialist to do so.	

Client Signature	Print Name	Date
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