Patient Profile – Chemical Peels

Name: _____ Birthday: __/__/____ Age: ____ Sex: _____
Address: _____ City: _____ State: ____ Zip: _____
Phone: _____ Email: _____

- Are you pregnant or lactating? ☐ Yes ☐ No (**Please consult with your obstetrician. Only the Oxygenating Trio or Detox Gel 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 have a sunburn/windburn/red face? ☐ Yes ☐ No (If so, why?) _____
- Are you in the habit of going to tanning booths? ☐ Yes ☐ No (*If within the past three weeks, decline treatment*)
- Do you currently use or receive depilatories or waxing (in the area where the peel is being performed)? ☐ Yes ☐ No (Discontinue use 7 days pre and post treatment)
- Are you applying any topical medications at this time in the area where the peel is being performed)? ☐ Yes ☐ No (If yes, please list.) _____
- Are you currently using any topical Retinoid prescriptions (Retin-A®, Renova®, Differin®, Tazorac®, Avage®?) ☐ Yes ☐ No What strength? _____ For how long? _____ (**Discontinue use 5-7 days before and after**) Consult your physician before discontinuing use of any prescription.
- Are you currently using Accutane? ☐ Yes ☐ No 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 treated with Accutane®.*) **Those who are currently taking 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
- Do you have regular collagen, Botox® or other dermal filler injections? ☐ Yes ☐ No (*Peels should follow injections by 2-5 days to prevent movement of the filler*)
- Have you recently had facial surgery? ☐ Yes ☐ No Describe: _____ How long ago? _____
- Have you recently had laser resurfacing? ☐ Yes ☐ No When? _____ What kind? _____
- What type of work do you do? _____
- Regular Airline travel? ☐ Yes ☐ No How often? _____
- Do you participate in vigorous aerobic activity of sports? ☐ Yes ☐ No What type? _____
- Do you 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? _____
- What is your natural eye color? _____
- What is your natural hair color? _____
- What is your skin tone? ☐ Pale/White ☐ Light ☐ Medium ☐ Reddish ☐ Freckled ☐ Sallow ☐ Lt. Olive ☐ Med. Olive
- Do you consider your skin: ☐ Sensitive ☐ Resilient ☐ Unsure?
- Describe your skin (check all that apply): ☐ Thick ☐ Thin ☐ Saggy ☐ Firm ☐ Normal ☐ Dry ☐ T-Zone/Combination ☐ Oily ☐ Acne ☐ Blackheads ☐ Milia ☐ Cysts ☐ Breakouts ☐ Acne-scarred ☐ Large pores ☐ Small pores ☐ Rosacea ☐ Eczema ☐ Freckled ☐ Sun-damaged ☐ Uneven/blotchy ☐ Mature ☐ Wrinkled ☐ Patchy dryness ☐ Sallow ☐ Melasma ☐ Perfume-stained ☐ Psoriasis ☐ Hyperpigmentation ☐ Hypopigmentation ☐ Dehydrated/lacking moisture ☐ Asphyxiated ☐ Telangiectasia/broken surface capillaries
- What is your daily care regimen? _____
- What are the cosmetic improvements you would like to see in your skin? _____

Treatment recommendation: _____
Patch test – Date: __/__/____ Solution: _____ Test Area: _____ Result: _____
Patient Signature: _____ Date: __/__/____
Clinician Signature: _____ Date: __/__/____