patient profile

Name:______________________________ DOB:______________ Age:_____ Sex:_____

Address:____

City:______________________________________ State:__________ Zip:__________

Phone:____________________________ E-mail:____________________________

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About You:

- What is your hereditary background? (check all that apply)
  - ❏ Nordic ❏ Irish ❏ Hispanic ❏ Mediterranean
  - ❏ English ❏ African American ❏ Asian ❏ Middle Eastern
  - ❏ Native American ❏ 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):
  - ❏ Normal ❏ Dry ❏ Freckled ❏ Psoriasis ❏ Sun-damaged ❏ Saggy ❏ Firm
  - ❏ Oily ❏ Acne ❏ Acne-scarred ❏ Breakouts ❏ Mature ❏ Wrinkled ❏ Psoriasis
  - ❏ Thin ❏ Thick ❏ Small pores ❏ Large pores ❏ Asphyxiated ❏ Eczema ❏ Rosacea
  - ❏ Sallow ❏ Cysts ❏ Milia ❏ Melasma ❏ Patchy dryness ❏ Uneven/Blotchy
  - ❏ Dehydrated/Lacking moisture ❏ Hyperpigmentation ❏ Hypopigmentation
  - ❏ Comedones/Blackheads ❏ T-Zone/Combination
  - ❏ Telangiectasia/Broken surface capillaries
- What are the changes you'd most like to see in your skin?

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Lifestyle:

- Are you pregnant or lactating? ❏ No ❏ 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? ❏ No ❏ Yes
  (**Remove contacts** if eyes are sensitive or if having microdermabrasion.)
- Do you currently have a sunburned/windburned/red face? ❏ No ❏ Yes
  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? ____________________

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Medical/Treatment History:

- Do you currently use depilatories or wax? ❏ No ❏ Yes
  (Discontinue use five days pre- and post-treatment.)
- Have you had a 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, Botox® or other dermal filler injections? ❏ No ❏ 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? ❏ No ❏ Yes
  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.)
- Are you currently using any topical retinoid prescriptions? ❏ No ❏ Yes
- 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) 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? ❏ No ❏ Yes
  Last breakout? __________________________
- Are you allergic/sensitive to (check all that apply) ❏ No ❏ Yes
  ❏ milk ❏ apples ❏ citrus ❏ grapes ❏ aloe vera
  ❏ aspirin ❏ perfumes ❏ latex ❏ hydroquinone ❏ mushrooms?
  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:________________

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