

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): Normal / 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

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?**(Remove contacts** if eyes are sensitive or if having microdermabrasion.) | No | Yes |
| Do you currently have a sunburned/windburned/red face? Why?  | No | Yes |
| Are you in the habit of going to tanning booths?(If within past 14 days, decline treatment. This practice should be discontinued due to increased risk of skin cancer and signs of aging.) | No | Yes |
| Do you participate in vigorous aerobic activity or sports? What type?  | No | Yes |
| 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 or seven days when receiving MD Peel (CCl3.)

before and after treatment or seven days when receiving MD Peel (CCl3). Consult your physician before discontinuing use of any prescription.)

|  |  |  |
| --- | --- | --- |
| Have you had a chemical peel or any type of procedure with a medical device? | No | Yes |
| Within the last 14 days?What type? \_ | No | Yes |
| Do you have regular collagen, Botox®, or other dermal filler injections?(Peels should precede or follow injections by two days to prevent movement of the filler or stinging at the injection site.) | No | Yes |
| Have you recently had laser resurfacing or facial surgery? Describe When?  | No | Yes |
| Are you currently taking any medications, topical or otherwise?(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 | 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 ofUltra Peel®, Sensi Peel®, Advanced Treatment Booster, Oxygenating Trio®, Hydrate: Therapeutic |  |  |
| Oat Milk Mask, or Revitalize: Therapeutic Papaya Mask or Detoxify: Therapeutic Charcoal Mask.) |
| Do you develop cold sores/fever blisters?Last breakout?  | No | Yes |
| Are you allergic/sensitive to (circle all that apply) milk / apples / citrus / grapes / aloe vera / aspirin / perfumes / latex / hydroquinone / mushrooms?If any other allergies, what?  | No | Yes |
| Have you ever used any other products that caused a bad reaction? Describe  | No | Yes |

Patient Signature: Date:

Clinician Signature: Date: