

## 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.

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Name (please print clearly)

Date of Birth

\_\_\_\_\_  
First Last M.I.  
Street Address

\_\_\_\_\_  
City State Zip Code

\_\_\_\_\_  
Home Phone E-Mail Address

Please check if presently using any of the following? (Please check all that apply.)

- Accutane       Glycolic Acid/Alpha Hydroxy Acid  
 Hydroquinone     Any prescription strength topical i.e. steroids, Retin-A, Tazorac, Differin, etc.

Which conditions do you want to improve? (Please check all that apply.)

- Hyperpigmentation (Brown Spots)       Acne/Acne Scarring       Sun Damage       Enlarged Pores  
 Fine Lines & Wrinkles       Surgical Facial Scars       Age Spots       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/sun block?       Yes       No  
Do you sunbathe or participate in outdoor activities?       Yes       No  
Do you have or have ever had acne?       Yes       No  
Are you using or have ever used any medications for acne?       Yes       No

Name of medications \_\_\_\_\_

Have you seen a Dermatologist in the past year?       Yes       No

If yes, list doctors 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

Do you have Epilepsy, Diabetes, or other auto-immune disorders?  Yes  No

***If yes, you will be treated only with a doctor's release!***

Are you presently under a physician's care for any reason?  Yes  No

***Explain*** \_\_\_\_\_

Do you use Bioré or snore strips?  Yes  No

Have you had any of the following?

- Cosmetic Surgery       Botox Injections       Skin Cancer       Dermatitis       Keloid Scarring  
 Laser Resurfacing/IPL       Chemical Peels       Hepatitis       Dermal Fillers       Other (Specify)

Are you allergic to Iodine or Seaweed?  Yes  No

Are you allergic to aspirin?  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?  Yes  No

Have you had permanent cosmetics?  Yes  No

If yes, where? \_\_\_\_\_

How is your general health?       Excellent       Good       Fair       Poor

If poor, explain: \_\_\_\_\_

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 non-invasive, light epidermal exfoliation consisting of any of the following: salicylic acid, mandelic 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