Patient Intake Form

Name: _____ Age: _____ DOB: _____ SEX: ☐ M ☐ F Date: _____

Address: _____ City: _____ ST: _____ Zip:_____

Circle All skin concerns(s) that you are seeking improvement upon.

☐ Pigment ☐ Aging ☐ Acne ☐ Rosacea ☐ Other _____

Are you pregnant or breastfeeding? _____ If yes, are contraindicated for a chemical peel.

Do you have permanent makeup? ☐ Yes ☐ No Do you wear contacts? ☐ Yes ☐ No

Have you recently had facial or body waxing or used a home depilatories? ☐ Yes ☐ No

Do you currently have sunburn or wind burned skin? ☐ Yes ☐ No

Do you have extended outdoor plans in the next 7 days? ☐ Yes ☐ No If yes, are contraindicated.

Do you plan to participate in vigorous exercise in the next 72-96 hours? ☐ Yes ☐ No

Have you had any active skin care treatments in the past 21 days? ☐ Yes ☐ No If yes, how long ago? _____

List all Topical products applied in the last 7 days _____

_____

List all prescriptions medication currently taken and in the past two weeks. _____

_____

(Note: patient Must be off Accutane for 6 months prior to peeling)

Have you recently undergone any surgery or laser treatments in the area to be treated? Yes No

If yes please provide detail

_____

Do you receive injectables? (Botox, fillers) ☐ Yes ☐ No Do you develop cold sores ? ☐ Yes ☐ No

Do you have any known Allergies or sensitivites (Please list) _____

Describe your ethnic background (English, Hispanic, Italian, German, Asian, Native American, African American, other.)

_____

How would you describe your Skin? ☐ SENSITIVE ☐ NORMAL ☐ RESILIENT