LE VERVE MEDISPA

Chemical Peel Patient Profile

Name: _____DOB: _____M/F:_____

Address: _____ Phone: _____

City: _____Province: _____Postal Code: _____

Are you pregnant or lactating? Yes: _____No:_____

Do you wear contact lenses? Yes:___No:___(**remove contacts** if eyes are sensitive or having microdermabrasion)

Do you currently have a sunburn/windburn/red face? Yes: _____Why? _____ No? _____

Do you use tanning booths? Yes?____ No: ___ (if within past 3 weeks decline treatment)

Are you currently using Biore©/snoring strips? Yes: ____No: ____ (discontinue use 5 days before and after treatment)

Are you currently using Retin-A©/Renova©/Differin©? Yes: ____ No: ____ What strength? ____

For how long? ____ How frequently? _____Where applied? _____(Discontinue use 5 days before and after treatment)

Are you currently using Accutane©? Yes: _____ No: _____ how long? _____

Are you currently using Tarozac©? Yes: _____ No: _____ how long?_____ (Discontinue use 10 days before and after treatment)

NOTE: Consult your physician before discontinuing use of any prescription)

Are you currently having microdermabrasion? Yes: _____ No: _____ how long? ___

Do you have regular collagen injections? Yes: ____ No: ____ (PCA SKIN© peels should precede collagen treatments by 7 days)

Do you have regular Botox© injections? Yes: ____ No: ____ (PCA SKIN© peels should precede Botox© treatments by 7 days)

Occupation? _____

Airline travel? Yes_____ How often?_____ No_____

Do you participate in vigorous acrobatic activities or sports? Yes____ No____ What type? _____

Have you ever had a peel? Yes____ No____ Within the last 14 days? Yes_____No_____

What kind? _____Describe your reaction _____

Have you recently had facial surgery? Yes____ No____ Describe:_____ how long ago?_____

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Have you recently had laser resurfacing? Yes_____ No_____ When? _____ What kind?_____

Do you smoke? Yes___ No___

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? (Antibiotics may increases sensitivity) _____

Describe your skin; (check all that apply): Thick ___ thin ___Saggy ___Firm ___Normal ____ Dry___ Oily ___

T-Zone/Combination ___ Acne ___ Comedones ___ Milia ___Cysts___ Breakouts___ Acne scarred ___

Large pores ___ Small pores ___Florid ____ Rosacea ___ Eczema ___ Freckled ___ Sun-Damaged ___

Uneven/ Blotchy___ Mature ___ Wrinkled ___ Patchy dryness on Sallow ___ Melasma ___ Perfumed stained

___ Hypo pigmented ___ Hyper pigmentation ___ Psoriasis ___ Dehydrated (lacking moisture) ___

Asphyxiated ___ Telangiectasia/ broken surface capillaries ____

Do you consider your skin: SENSITIVE ___ RESILIENT ___ or NOT SURE____? (Check)

Eye color: Blue___ Green___ Hazel ___ Gray ___ Lt. Brown ___ Med. Brown ___ Dk. Brown___

Hair Color: Blonde ___ Red ___ Lt. Brown ___ Med Brown ___ Dk. Brown___ Black ___

Gray/ Silver ___ White ___

Skin Tone: Fair ___ Light ___ Medium ___ Reddish ___ Freckled ___ Lt. Olive ___ Med. Olive ___

Dark Olive ___ Lt. Brown ___ Med. Brown ___ Dark Brown ___ Soft Black ___ Black ___Sallow ___

What is your hereditary background? _____

Have you ever used products that caused a bad reaction? Yes ____ No ____ Describe _____

What are the cosmetic improvements you would like to see in your skin?

_____

Treatment Recommendation: _____

Patch Test: Date_____ Solution _____ Test Area _____ Result

Technician Signature _____ Date

Patient/ Client Signature_____ Date