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 dincontinuing 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? _____
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 _____