

CHEMICAL PEEL CONSENT FORM

This form, together, with the general information sheet, is designed to provide with information for making an informed decision regarding your chemical peel. If you have any questions, please do not hesitate to ask a member of our staff. While a chemical peel (or series of mild acid treatments) is effective in most cases, no guarantee can be made that a specific individual will benefit from the treatment.

1. Prior to receiving this treatment, I have been candid in revealing any condition that may have a bearing on this procedure, such as, pregnancy, recent facial peels or surgery, allergies, tendencies to cold sores and fever blisters, use of Retin-A, Accutane or Hormones.
2. I understand there may be some degree of minor discomfort, i.e., scratchiness, itchiness.
3. I understand there are no guarantees to this procedure
4. I understand that to achieve maximum results, I will need several ongoing treatments and will need to use a daily product over a period of time.
5. I understand that the possibility of irritation and redness exists and that I should notify my skin care professional when irritation persists.
6. I will follow the home care program specifically designed for me without changing or adding any products without consulting with my skin care professional.
7. I have read the enclosed consultation and understand the contents.
8. **I AGREE TO ALL OF THE ABOVE TO HAVE THIS TREATMENT PERFORMED ON ME AND WILL FOLLOW ALL PRESCRIBED DIRECTIONS REGARDING PEEL CARE.**

MY QUESTIONS HAVE BEEN ANSWERED BY THE STAFF TO MY COMPLETE SATISFACTION. I ACCEPT THE RISKS AND COMPLICATIONS OF THE PROCEDURE.

Patient or Person Authorized to Sign for Patient

Please Print Name Here

DATE: _____

WITNESS: _____



SKIN CARE QUESTIONNAIRE

Date: _____
Name: _____ Birth Date: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Primary Phone: _____ Secondary Phone: _____
Referred by: _____

PERSONAL DATA

Smoker (circle one): yes no **Pregnant (circle one):** yes no
Cosmetic surgery (circle one): yes no **If yes, when:** _____
Define procedure(s): _____
Medication (circle one): yes no **If yes, what kind(s)?:** _____
Any health problems? (circle one): yes no **If yes, explain:** _____
Any allergic reactions to medication? (circle one): no yes **If yes, describe:** _____
Do you have any allergies? (circle one): yes no
Do you suntan? (circle one): yes no
Do you use sunscreen? (circle one): yes no
Please name the brand of products you are currently using:
Cleanser: _____ Toner: _____
Moisturizer: _____ Scrub: _____
Mask: _____ Buff Puff: _____
Other: _____
Have you ever used Retin-A? (circle one): yes no **If yes, what strength?:** _____
Have you ever been treated with Phenol or Trichloroacetic acid? (circle one): yes no
Have you ever used Hydroquinone (skin lightener)? (circle one): yes no
Have you ever been on Accutane? (circle one): no yes **If yes, when?:** _____
Have you ever had (circle all that apply): herpes hives cold sores fever blisters keloids **If yes, when?:** _____
How would you characterize your skin (circle one): Sensitive Rough Dry Oily/Acne-prone
If you had one complaint about your skin, what would it be?: _____
Describe your skin in three words: _____
Additional comments/concerns: _____