

PATIENT PROFILE

NAME _____ DOB _____ AGE _____ SEX _____
 ADDRESS _____ PHONE _____
 CITY _____ STATE _____ ZIP _____
 E-MAIL ADDRESS _____

Are you pregnant or lactating? Yes ___ No ___ (If so only the Oxy Trio and Detox Gel is appropriate)
 Do you wear contact lenses Yes ___ No ___ (remove contacts before treatment)
 Do you have permanent makeup? Yes ___ No ___ If so, to what areas of face? _____
 Do you currently have a sunburn/windburn/red face? Yes ___ No ___ Why _____
 Are you in the habit of going to tanning booths? Yes ___ No ___ (if within 3 wks decline treatment)
 Are you currently using Biore or snore strips? Yes ___ No ___ (stop use 5 days before and after treatment)
 Are you currently using depilatories? Yes ___ No ___ (discontinue use 7 days before and after treatment)
 Are you currently using Retin-A/Renova/Differin? Yes ___ No ___ 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? _____ (Discontinue use 10 days before and after treatment-make sure you consult the prescribing physician before stopping use of any prescription)
 Do you have regular collagen injections? Yes ___ No ___ (peels/laser/microderm should precede injections by 7 days)
 Do you have regular Restylane injections? Yes ___ No ___ (peels/laser/microderm should precede injections by 7 days)
 Do you have regular Botox injections? Yes ___ No ___ (peels/laser/microderm should precede injections by 7 days)
 Have you ever had a peel? Yes ___ No ___ within the last 14 days? Yes ___ No ___ Have you recently had facial surgery? Yes ___ No ___ Describe _____
 Have you recently had laser resurfacing? Yes ___ No ___ When _____ What kind? _____
 Do you develop cold sores? Yes ___ No ___ Last Breakout? _____
 Have you had laser hair removal Yes ___ No ___ when & how many times _____ What areas treated? _____
 Have you waxed? Yes ___ No ___ How long ago _____ what areas? _____
 Do you smoke? Yes ___ No ___
 Are you allergic/sensitive to: (check all that apply) milk ___ apples ___ citrus ___ grapes ___ aloe vera ___ aspirin ___ perfumes ___ latex ___ hydroquinone ___ mushrooms ___ any other allergies, what? _____
 Are you sensitive to alcohol-based products? Yes ___ No ___
 Are you taking any medication at this time? (antibiotics may increase sensitivity)
 Describe your skin: (check all that apply) thick ___ thin ___ saggy ___ firm ___ normal ___ dry ___ acne scarred ___ large pores ___ small pores ___ flrid ___ rosacea ___ eczema ___ freckled ___ T-zone/combination ___ oily ___ acne ___ comedones ___ milia ___ cysts ___ breakouts ___ sallow ___ melasma ___ perfume stained ___ hypo-pigmented ___ hyper-pigmented ___ psoriasis ___ dehydrated ___ asphyxiated ___ telangiectaia/broken surface capillaries ___
 Do you consider your skin: sensitive ___ resilient ___ not sure ___
 Eye color: blue ___ green ___ hazel ___ gray ___ light brown ___ medium brown ___ dark brown ___
 Hair color: blonde ___ red ___ light brown ___ medium brown ___ dark brown ___ black ___ silver/gray ___ white ___
 Skin tone: pale/white ___ light ___ medium ___ reddish ___ freckled ___ light olive ___ medium olive ___ dark olive ___ light brown ___ medium brown ___ dark brown ___ soft black ___ black ___ sallow ___
 What is your hereditary background? _____
 Have you ever used any products that caused a bad reaction? Yes ___ No ___ Describe _____
 What is your daily home care regimen? _____
 What are the cosmetic improvements you would like to see in your skin? _____

Treatment recommendations: _____

Patch Test: Date _____ Solution _____ Test Area _____ Result _____

Technician Signature: _____ Date: _____
 Patient/Client Signature _____ Date: _____