NOVAS, DOHR, COLL
SPECIAL' SERVICES

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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___florid___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: _____