PATIENT PROFILE

Name:_____ DOB:_____ Age: _____ Sex:_____
Address:_____Phone:_____
City:_____ State: _____Zip:_____
Are you pregnant? Yes ____ No____ **(If so, only the Oxy Trio and Detox Gels are appropriate)**
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?_____ (may need to decline treatment) No____
Are you in the habit of going to tanning booths? Yes____No____ (if within past three weeks, decline treatment)
Do you currently get facial waxing/electrolysis/or use depilatories?Yes___No___(wait 5 days between treatments)
Are you currently using Bioré/snore strips? Yes____ No____ (Discontinue use 5 days 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 treatment)
Are you currently using Accutane? Yes____No____How long?_____
Are you currently having microdermabrasion? Yes____No____How long?_____
Do you have regular collagen injections?Yes__No__(PCA Peel® should precede collagen treatments by 7 days)
Do you have regular Botox injections? Yes____No____(PCA Peel® should precede Botox treatments by 7 days)
What type of work do you do?_____Airline travel? Yes____ How often?_____No____
Do you participate in vigorous acrobic activity 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___Any other allergies?Yes___No__If so, to what?_____
Are you sensitive to alcohol based products?Yes____No____
Are you taking any medication at this time? (antibiotics increase sensitivity) _____
Tell me about your skin; describe it for me (check those that apply): Thick____ Thin____Saggy____Firm____
Normal____Dry____T-Zone/Combination____ Oily____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____Perfume-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: Pale/White____Light____Medium____Reddish____Freckled____Lt. Olive____Med. Olive____
Dark Olive____Lt. Brown____Med. Brown____Dark Brown____Soft Black____Black____Sallow____
What is your hereditary makeup? _____
Are you using glycolic/AHA home care products?Yes___No___If so, which one(s)?_____
How does your skin react to them? _____
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 recommendation: _____
_____
Patch Test: Date_____Solution_____Test area_____Result_____
Technician Signature_____ Date_____

Patient/Client Signature_____Date_____

We urge you to call the patient the next day for reactions and comments.