

Prior to receiving treatment, I have been candid in revealing any condition that may have bearing on this procedure, such as: Pregnancy (if so, only the Oxygenating Trio or Detox Gel is appropriate), recent facial surgery, allergies, tendency to cold sores/fever blisters, use of Retin-A<sup>®</sup>, Accutane<sup>®</sup>, Tazorac<sup>®</sup>, Differin<sup>®</sup> or Avage<sup>®</sup>.

I understand there may be some degree of discomfort; i.e., stinging, pin-pricking sensation, hotness, or tightness.

I understand there are no guarantees as to the results of this treatment, due to many variables, such as: age, condition of skin, sun damage, smoking, climate, etc. I understand I may or may not actually peel, that each case is individual.

I understand this treatment is a cosmetic treatment and that no medical claims are expressed or implied.

I understand that to achieve maximum results, I may need several treatments.

I understand that although complications are very rare, sometimes they may occur and that prompt treatment is necessary. In the event of any complications, I will immediately contact the doctor/technician who performed the treatment.

**I agree to refrain from tanning in tanning booths while I am undergoing treatment, and during the 14 days following the end of treatment. \*\*PCA SKIN recommends discontinuing all use of tanning beds.**

**I understand that direct sun exposure is prohibited while I am undergoing treatment and the use of sunblock protection with a minimum of SPF 15 is mandatory.**

**I have not had any other peel treatment of any kind within 14 days of the treatment. I understand I cannot have another treatment within 14 days of this treatment, whether the treatment is performed at this location or any other location.**

***I hereby agree to all of the above and agree to have this treatment be performed on me. I further agree to follow all post-peel care instructions as I am directed.***

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Initials:** \_\_\_\_\_

**Signature of Clinician:** \_\_\_\_\_

**For Clinician Use Only**

Patient Name: \_\_\_\_\_ Contact Phone #: \_\_\_\_\_

Date: \_\_\_\_\_

Protocol: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Area Treated: (circle)    face    neck    chest    hand    arms

Other: \_\_\_\_\_

\_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_



# PATIENT PROFILE

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Are you pregnant or lactating? Yes \_\_\_\_\_ No \_\_\_\_\_ (If so, only the Oxygenating Trio or Detox Gel is appropriate)

Do you wear contact lenses? Yes \_\_\_\_\_ No \_\_\_\_\_ (remove contacts if eyes are sensitive or having microdermabrasion)

Do you have permanent makeup? Yes \_\_\_\_\_ No \_\_\_\_\_ (if so, to what areas of the face?) \_\_\_\_\_

Do you currently have a sunburn/windburn/red face? Yes \_\_\_\_\_ Why? \_\_\_\_\_ No \_\_\_\_\_

Are you in the habit of going to tanning booths? Yes \_\_\_\_\_ No \_\_\_\_\_ (if within past three weeks, decline treatment)

Are you currently using Bioré®/snore strips? Yes \_\_\_\_\_ No \_\_\_\_\_ (Discontinue use 5 days before and after treatment)

Are you currently using dipilatories? Yes \_\_\_\_\_ No \_\_\_\_\_ (Discontinue use 7 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? \_\_\_\_\_ It is OK to apply ONE layer of Ultra Peel® I, Sensi Peel®, Ultra Peel® II, Esthetique Peel™ or Oxy Trio to skin that has been treated with Accutane.

**Those who are currently taking Accutane should be directed to their dispensing physician.**

Are you currently using Tazorac® or Avage®? Yes \_\_\_\_\_ No \_\_\_\_\_ How long? \_\_\_\_\_ (Discontinue use 10 days before and after treatment) NOTE: consult your physician before discontinuing use of any prescription.

Have you had a chemical peel or any type of procedure with a medical device? Yes \_\_\_\_\_ No \_\_\_\_\_ Within the last 14 days? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you have regular collagen injections? Yes \_\_\_\_\_ No \_\_\_\_\_ (peels should precede injections by 7 days)

Do you have regular Restylane® injections? Yes \_\_\_\_\_ No \_\_\_\_\_ (peels should precede injections by 7 days)

Do you have regular Botox® injections? Yes \_\_\_\_\_ No \_\_\_\_\_ (peels should precede injections by 7 days)

What type of work do you do? \_\_\_\_\_ Airline travel? Yes \_\_\_\_\_ How often? \_\_\_\_\_ No \_\_\_\_\_

Do you participate in vigorous aerobic activity or sports? Yes \_\_\_\_\_ No \_\_\_\_\_ What type? \_\_\_\_\_

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? Yes \_\_\_\_\_ No \_\_\_\_\_

Are you taking any medication at this time? (antibiotics may increase sensitivity) \_\_\_\_\_

Describe your skin; (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 \_\_\_\_\_ Hypopigmented \_\_\_\_\_ Hyperpigmentation \_\_\_\_\_ Psoriasis \_\_\_\_\_

Dehydrated(lacking moisture) \_\_\_\_\_ Asphyxiated \_\_\_\_\_ Telangiectasia/broken surface capillaries \_\_\_\_\_

Do you consider your skin SENSITIVE \_\_\_\_\_ RESILIENT \_\_\_\_\_ NOT SURE \_\_\_\_\_? (Check)

Eye color: Blue \_\_\_\_\_ Green \_\_\_\_\_ Hazel \_\_\_\_\_ Gray \_\_\_\_\_ Lt. Brown \_\_\_\_\_ Med. Brown \_\_\_\_\_ Dk. Brown \_\_\_\_\_

Hair color: Blond \_\_\_\_\_ 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 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 recommendation: \_\_\_\_\_

Patch test: Date \_\_\_\_\_ Solution \_\_\_\_\_ Test Area \_\_\_\_\_ Result \_\_\_\_\_

Clinician Signature \_\_\_\_\_ Date \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_