Client Health History: Advanced Chemical Peel Health History Intake

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home/Cell Phone: _____ Work: _____

Email: _____ Preferred Contact: Cell ☐ Work ☐ Emai ☐

Emergency contact name: _____ Phone _____

Relationship to you: _____

SKIN TYPE: Review the skin types below, using the Fitzpatrick Scale, and check the one that best describes your skin. This information will be used by your technician to determine the most appropriate way to approach your treatment(s):

☐ I. Very fair skin; blonde or red hair; light-colored eyes; freckles common

☐ II. Fair skinned; light hair, light eyes

☐ III. Very common skin type; fair; eye and hair color vary

☐ IV. Mediterranean Caucasian skin; medium to heavy pigmentation

☐ V. Mideastern skin; rarely sun sensitive

☐ VI. Black skin; rarely sun sensitive

Are you of Asian heritage (Class V) and/or have a history of keloid scarring? ☐ Yes ☐ No

Please list the products you use regularly:

Facial Cleanser _____ Moisturizer _____

Toner _____ Serum _____

Scrubs _____ Sunscreen _____

Retinol _____ Glycolic Acid _____

Enzymes _____ Peptides or Growth Factors _____

Cosmetic History

How would you describe your skin? Normal ☐ Combination ☐ Oily ☐ Dry ☐

When were you last exposed to the sun (including tanning beds)? _____

Do you use sunless tanning products? Yes ☐ No ☐ If yes, when was it last applied? _____

Do you have hyperpigmentation (darkening of the skin) or hypopigmentation (lightening of the skin) or marks after physical trauma? Yes ☐ No ☐ If yes, please describe _____

_____

Have you had chemical peel treatments in the past? Yes ☐ No ☐ If yes, when? _____

Describe your experience _____

_____

Continued ⇨

Are you currently using, or have you used in the past year, any of the following?

Isotretinoin (Accutane) ☐ Tretinoin (Retinoic Acid) ☐ Acyclovir ☐ Glycolic Acid ☐ Salicylic Acid ☐

Adapalene (Differin) ☐ Hydroquinone ☐ Azelaic Acid ☐ Lactic Acid ☐ Spironolactone ☐

If yes, when? _____

Are you using any topical creams, lotions, or oral antibiotics for acne, skin cancer, antiaging or hyperpigmentation?
Please List: _____

Have you ever had any of the following injectables or implants?
Botox ☐ Juvederm ☐ Radiesse ☐ Restylane ☐ Perlane ☐ Silicone ☐
Collagen ☐ Sculptra ☐ Dysport ☐ Other: _____
If yes, when? _____ What body area(s)? _____

Have you had any facial cosmetic surgeries/procedures, piercings, metal implants, tattoos, or use of a pacemaker within the past year? Yes ☐ No ☐ If yes, when?_____

Have you had any laser resurfacing treatments in the past six weeks? Yes ☐ No ☐ If yes, when? _____

Have you used any of the following hair removal methods in the past six weeks?
☐ Shaving ☐ Waxing ☐ Electrolysis ☐ Tweezing ☐ Threading ☐ Depilatories

Health History
Have you had chemotherapy in the past 6 months? Yes ☐ No ☐

Do you have any allergies to medications, food, latex, topical products, and/or other substances? _____
_____

Do you have any of the following conditions?
☐ Eczema ☐ Dermatitis ☐ Hormone imbalance ☐ Pregnancy and/or breastfeeding ☐ Autoimmune disease ☐ Herpes Simplex (cold sore) ☐ Diabetes

Do you have any other health condition(s) not mentioned here? Yes ☐ No ☐
If yes, please list _____

Are you currently on birth control? Yes ☐ No ☐ If yes, please describe _____

Have you consumed drugs or alcohol in the last 24 hours? Yes ☐ No ☐

Please list all vitamins and supplements including herbal remedies you take regularly _____
_____

Please list all current medications including aspirin, ibuprofen, blood thinners, etc. you take regularly _____
_____

Is there anything else you would like us to know? _____
_____

I certify that the preceding medical, personal, and skin history statements are true and correct. I am aware that it is my responsibility to inform the esthetician of my current medical or health conditions and to update this history. A current medical history is essential to execute appropriate treatment procedures.

Client Name (Printed) _____

Client Name (Signature) _____ Date: _____

Esthetician/Technician: _____ Date: _____