Name: _____

Are you pregnant or lactating? ◯ Y ◯ N (Please consult with your obstetrician. Only the oxygenating Trio or Detox Gel Deep Pore Treatment is appropriate.)

Do you wear contact lenses? ◯ Y ◯ N (Remove contacts if eyes are sensitive or if having microdermabrasion.)

Do you have permanent makeup? ◯ Y ◯ N (If so, to what areas of the face?) _____

Do you currently use or receive depilatories or waxing? ◯ Y ◯ N (Discontinue use five day pre/post treatment.)

Do you currently have a sunburn/windburn/ red face? ◯ Y ◯ N Why? _____

Are you in the habit of going to tanning booths? ◯ Y ◯ N (If within past 14 days, decline treatment. This practice should be discontinued due to increased risk of skin cancer and signs of aging.)

Are you applying any topical medications at this time? ◯ Y ◯ N If so, what? _____ (High percentages of certain ingredients may increase sensitivity)

Are you currently using any topical Retinoid prescriptions (Tretinoin® | RetinA® | Isotrentinoin®| Accutane® | Renova® | Differin® | Tazorac® | Avage® | EpiDuo® | Ziana®)? ◯ Y ◯ N

What strength? _____

Duration? _____ (Discontinue use five days before and after treatment. Consult your physician before discontinuing any prescription.)

Are you currently undergoing Isotretinoin therapy (Accutane®)? ◯ Y ◯ N For how long? _____ (It is OK to apply ONE layer of Ultra Peel ®1, SensiPeel®II, Esthetique Peel or Oxy Trio to skin that has been undergoing Isotretinoin therapy (Accutane®)). Those who are currently undergoing Isotretinoin therapy (Accutane®) should be directed to their dispensing physician.

Have you had a chemical peel or any type of procedure with a medical device? ◯ Y ◯ N

Within the last 14 days ◯ Y ◯ N What type? _____

Do you have regular collagen, Botox or other dermal filler injections? ◯ Y ◯ N (Peels should precede or follow injections by two days to prevent movement of the filler or stinging at the injection site.)

Have you recently had facial surgery? ◯ Y ◯ N Describe: _____ How long ago? _____

Have you recently had laser resurfacing? ◯ Y ◯ N When? _____ What type? _____

What type of work do you do? _____ Regular airline travel? ◯ Y ◯ N How often? _____

Do you participate in vigorous aerobic activity or sports? ◯ Y ◯ N What type? _____

Do you smoke or use tobacco? ◯ Y ◯ N _____

Do you develop cold sores/fever blisters? ◯ Y ◯ N Last breakout? _____

Are you allergic/sensitive to: (Check all that apply) ◯ Milk ◯ Apples ◯ Citrus ◯ Grapes
◯ AloeVera ◯ Aspirin ◯ Perfumes ◯ Latex ◯ Hydraquinone ◯ Mushrooms

If any other allergies, what? _____

Are you sensitive to alcohol-based products? ◯ Y ◯ N

Have you ever used any other products that caused a bad reaction? ◯ Y ◯ N Describe: _____

Are you taking any medication at this time? (Antibiotics may increase sensitivity) _____

What is your hereditary background? _____

Natural eye color: ◯ Blue ◯ Green ◯ Hazel ◯ Gray ◯ Lt. Brown ◯ Med Brown ◯ Dk Brown

Natural hair color: ◯ Blond ◯ Red ◯ Lt Brown ◯ Med Brown ◯ Dk Brown ◯ Black ◯ Gray/Silver ◯ White

Skin tone: ◯ Pale/White ◯ Light ◯ Medium ◯ Reddish ◯ Freckled ◯ Sallow ◯ Lt.Olive
◯ Med. Olive ◯ Dark Olive ◯ Lt Brown ◯ Med Brown ◯ Dk Brown ◯ Soft Black ◯ Black

Do you consider your skin: ◯ Sensitive ◯ Resilient ◯ Unsure

Describe your skin (check all that apply):

◯ Normal	◯ Dry	◯ T-Zone/Combination	◯ Thick	◯ Thin
◯ Saggy	◯ Firm	◯ Oily	◯ Mature	◯ Wrinkled
◯ Milia	◯ Cysts	◯ Breakouts	◯ Small pores	◯ Large pores
◯ Sallow	◯ Florid	◯ Rosacea	◯ Eczema	◯ Freckled
◯ Sun-damaged	◯ Melasma	◯ Hyperpigmentation	◯ Perfume-stained	◯ Dehydrated
◯ Patchy dryness	◯ Psoriasis	◯ Hypopigmentation	◯ Asphyxiated	◯ Uneven/blotchy
◯ Acne-scarred	◯ Acne	◯ Comedones/Blackheads	◯ Telangiectasia/broken capillaries	

What are the changes you would most like to see in your skin? _____

Click here to print and bring with you

Consent for treatment: _____ Date: _____

Esthetician: _____ Date: _____