



Peel Intake Form

Name: _____ Email Address: _____

DOB: _____ Age: _____ Sex: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

• Are you pregnant or lactating? Yes ___ No ___ **(Please consult with your obstetrician.**

- Do you wear contact lenses? Yes ___ No ___ **(Remove contacts** if eyes are sensitive or if having microdermabrasion.)
- Do you have permanent makeup? Yes ___ No ___ (If so, to what areas of the face?) _____
- Do you currently use or receive dipilatories or waxing? Yes ___ No ___ (Discontinue use five days pre- and post-treatment.)
- 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 past 14 days, decline treatment; we recommend this practice is discontinued altogether.)
- Are you applying any topical medications at this time? Yes ___ No ___ Which one(s)? _____
(High percentages of certain ingredients may increase sensitivity)
- Are you currently using any topical Retinoid prescriptions (tretinoin/Retin-A®/Renova®/Differin®/Tazorac®/Avage®/EpiDuo™/Ziana®)? Yes ___ No ___ What strength? _____ For how long? _____ (Discontinue use 5 days before and after treatment. Consult your physician before discontinuing use of any prescription.)
- Are you currently using Accutane®? Yes ___ No ___ For how long _____

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

- Have you had a chemical peel or any type of procedure with a medical device? Yes ___ No ___
Within the last 14 days? Yes ___ No ___ What type? _____
- Do you have regular collagen, Botox® or other dermal filler injections? Yes ___ No ___ (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? Yes ___ No ___ Describe: _____ How long ago? _____
- Have you recently had laser resurfacing? Yes ___ No ___ When? _____ What type? _____
- What type of work do you do? _____ Regular airline travel? Yes ___ No ___ How often? _____
- Do you participate in vigorous aerobic activity or sports? Yes ___ No ___ What type? _____
- Do you smoke or use tobacco? Yes ___ No ___
- Do you 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 ___
- Have you ever used any other products that caused a bad reaction? Yes ___ No ___ 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 ___ Dark 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 ___ Acne ___ Comedones/Blackheads ___ Milia ___ Cysts ___ Breakouts ___ Acne-scarred ___ Large pores ___
Small pores ___ Florid ___ Rosacea ___ Eczema ___ Freckled ___ Sun-damaged ___ Melasma ___ Hyperpigmentation ___
Perfume-stained ___ Hypopigmentation ___ Uneven/blotchy ___ Mature ___ Wrinkled ___ Patchy dryness ___ Sallow ___
Psoriasis ___ Dehydrated/lacking moisture ___ Asphyxiated ___ Telangiectasia/broken surface capillaries ___

Patient Signature: _____ Date: _____

Clinician Signature: _____ Date: _____