THE PERFECT DERMA™
A chemical peel, RX

THE PERFECT DERMA ™ PEEL

PATIENT INTAKE FORM

PATIENT NAME: _____ DOB: _____ M/F _____

Address: _____

Email: _____ Phone: _____

Are you currently pregnant, attempting to conceive, or breast feeding? □ **YES** □ **NO**
If the answer is yes, you are contraindicated to a chemical peel.

List all allergies: _____

Current Medications and Supplements: _____

_____

Are you currently under the care of a physician? □ **YES** □ **NO**

If yes, why? _____

Please take a moment to carefully read the following list of conditions and questions below. Check any that have affected your health either recently or in the past. A referral from your primary care provider may be required prior to service being provided.

- ☐ Wearing contact lenses
- ☐ Hormonal Therapy
- ☐ Diabetes
- ☐ Migraines High level of stress
- ☐ Cardiac or Circulatory Problems
- ☐ HIV Positive
- ☐ Blood Clots
- ☐ Hepatitis
- ☐ Recent Illness
- ☐ Metal or Silicone Implants
- ☐ Thyroid (over or under active)
- ☐ High or Low Blood Pressure
- ☐ Epilepsy or Seizures
- ☐ Sinus Infection
- ☐ Arthritis or Joint Swelling
- ☐ Fibromyalgia
- ☐ Lack of normal skin sensation
- ☐ Multiple Sclerosis
- ☐ Contagious Conditions
- ☐ Recent Surgery
- ☐ Difficulty relaxing
- ☐ Heart Condition / Pacemaker
- ☐ Tension Headaches
- ☐ Skin Rashes
- ☐ Diabetes
- ☐ Dry Skin
- ☐ Thrombosis/Phlebitis
- ☐ Herpes Virus (cold sores)
- ☐ Skin Cancer – or other

Are you allergic to any cosmetic ingredient, medication or food? Please List:

_____

List all health conditions currently undergoing treatment and within the past 12 months.

_____

List all active treatments that you have had in the past 6 months.
(Laser, IPL, Dermaplaning, Microneedling, Microdermabrasion, Thermage, etc.)

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_____

Patient Skin Concerns and Goals: _____

_____

Ethnicity- what is your genetic background? (English, Irish, Latino, Middle Eastern, African American, etc.)

_____

Lifestyle:

Smoking: _____ per day

Alcohol: _____ per day

Caffeinated Beverages: _____ per day

Water intake: _____ glasses (oz.) per day

Exercise: _____

Amount of sleep each night: _____

Current Daily Skincare Regimen:

AM _____

PM _____

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____