

PCA FACIAL INTAKE FORM

patient profile

Name: _____ DOB: _____ Age: _____ Sex: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____ E-mail: _____

- Are you pregnant or lactating? Yes ___ No ___ (Please consult with your obstetrician. Only the Oxygenating Trio or Detox Gel Deep Pore Treatment is appropriate.)
- 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 dilatories 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. 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? Yes ___ No ___ Which one(s)? _____ (High percentages of certain ingredients may increase sensitivity)
- Are you currently using any topical Retinoid prescriptions (tretinoin/Retin-A®/isotretinoin/Accutane®/Renova®/Differin®/Tazorac®/Avage®/EpiDuo™/Ziana®)? Yes ___ No ___ What strength? _____ For how long? _____ (Discontinue use five days before and after treatment. Consult your physician before discontinuing use of any prescription.)
- Are you currently undergoing isotretinoin therapy (Accutane®)? Yes ___ No ___ For 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 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? 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 ___
- What are the changes you'd most like to see in your skin? _____

Patient Signature: _____ Date: _____

Clinician Signature: _____ Date: _____