Acne Questionnaire & Consent Form

Name: _____ Date of Birth: _____

Address: _____ City_____ State____ Zip_____

Cell Phone: _____ E-Mail: _____

Skin Care Treatments

Do you currently get regular facial treatments? YES NO
How often? _____ How does the skin respond after treatments? _____

Have you ever had chemical peels, laser, or microdermabrasion? YES NO
In the last month YES NO If yes, please list: _____

Have you hair removal (laser/waxing) in the past week? YES NO If yes, please list: _____

Do you use Retin-A, Renova, Adapalene Hydroxyl Acid, Accutane, or Retinol/Vitamin A derivative products, or any other Topical Prescriptions? YES NO If yes, please list:
_____

Have you ever had any reaction to any products or anything you have put on your face? YES NO
If yes, please list products: _____

Skin Care Conditions/Concerns

Which of the following best describes your skin type? (**Please circle one I, II, III, IV, V, VI**)
I *Creamy complexion - Always burns easily, never tans* ***II*** *Light Complexion - Always burns, tans slightly*
III *Light/Matte Complexion - Burns moderately, tans gradually* ***IV*** *Matte Complexion - Seldom burns, always tans*
V *Brown Complexion - Rarely burns, deep tan* ***VI*** *Black Complexion - Never burns, deeply pigmented*

How Sensitive would you rate your skin 1-5? *1 Not Sensitive at all – 5 Extremely Sensitive*
(**Please circle one *1, 2, 3, 4, 5)*** please explain:_____

Skin Type: o Oily o Congested o Combination o Sensitive o Rosacea o Acneic
o Dry/Dehydrated o Aging o Hyperpigmentation o Normal o Other: _____

Eyes: o dehydrated o wrinkles o puffiness o dark circles o Other: _____

Face: o Blackheads o Whiteheads o Excessive oil/Shine o Rosacea
o Dry/Dehydrated o Redness/ruddiness o Cyst o Pimples/Pustules o Sensitive
o Flaky o Couperose o Sun spot/liver spot/brown spot o Other: _____

Please explain your skin concerns in depth:_____

_____

_____

Lifestyle, Family & Medical History

Are you taking any medications? YES NO If yes, please list:
_____

Do you work outside or spend a lot of time outdoors, if so please explain?
_____

Do you have sinus issues? _____

Do you smoke or have you in the past? YES NO If yes, how much per day?_____

List any known allergies
_____

Stress level 1 – 10 _____

Do you have an allergic reaction to insect bites? YES NO If yes, please explain:
_____

Have any family members suffered from acne or rosacea? YES NO If yes, please explain:
_____

How long have you suffered from acne or rosacea?
_____

Known Triggers that aggravate your acne or rosacea? YES NO please explain:
_____

Female Clients Only:
Are you taking oral contraceptives? YES NO please explain: _____

Any recent changes to or from your contraceptive treatment? YES NO
If so, what and when: _____

Are you pregnant or trying to become pregnant? YES NO - Are you lactating? YES NO

Are your menstrual cycles regular? YES NO - Does your menstrual cycle increase break outs? YES NO

Any menopause problems? YES NO Please specify: _____

Are you undergoing any hormone replacement therapy? YES NO Please specify: _____

Male Clients Only:
What is your current shaving system? o Wet shave o Electric

Do you experience irritation from shaving? YES NO Ingrown hairs? YES NO

Please list any Medical Conditions_____

_____

Are you under a dermatologist's or other skin physician's care? YES NO

If yes, doctor's name: _____

Skin Care Products & Regimen

Product	*Name*	*How Often Its Used*
Cleanser		
Astringent		
Toner		
Serums		
Moisturizer		
Oils		
Exfoliants		
Mask		
Acne Topical		
Sunscreen		
Foundation		
Blush		
Other		

Additional Notes On Skin Care Products:_____

_____

Prescribed Medications

Medication	*Date Prescribed/Start*	*End Use*	*Notes*
Accutane			
Androstendione			
Antibiotics			
Avita			
Azelex			
Benzoyl Peroxide			
Cleocin-T			
Corticosteroids			
Danzol			
Differin			
E-mycin-T			
Gonadotrophin			
Progesterone			
Retin A/Renova/Vitamin A			
Steroids			
Spironolactone			
Tazorac			
Testosterone			
Thyroid			
Other Medications			

Diet

Food/Beverage	How Often	Notes		Food/Beverage	How Often	Notes
Alcohol				Vegetables		
Water				Fruit		
Soda				Fish		
Coffee				Fast Food		
Gluten				Peanuts/Nuts		
Soy				Eggs		
Dairy				Other		

Additional Notes On Food Intake:_____
_____

I have given all information of any over the counter or prescription medications that I use regularly, and I am not presently using (nor have I used in the last year) isotretinoin (Accutane), excessive Retin-A. I have not had any recent facial surgeries, injectables, permanent cosmetics or other chemical peels that I have not disclosed to my skin therapist. If am currently pregnant or lactating, I am allowing my Aesthetician to perform these chemical treatments at my own risk and will not hold him/her liable for any negative reactions. I am over the age of eighteen (18). I have not had a any recent radioactive or chemotherapy treatments, sunburn, windburn or broken skin. I have not recently waxed or used a depilatory on the area to be treated. I am not currently being treated for any autoimmune disease, diabetes, active herpes blisters or any other existing condition that may interfere with the positive outcome of this treatment. _____. I understand that I should not have a chemical peel if I intend to continue to have excessive sun exposure. It has been explained to me that treated area will be more sensitive to the sun and other environmental factors as a result of the treatment and will require use of mineral sunscreen (DERMA-CEUTIX Anti-Aging SPF 35). _____.

I consent to the taking of photographs to monitor treatment effects, as desired to recommended by my Aesthetician _____.

I understand that the results expected may not be guaranteed and that for maximum results, more than one application may be required. The rate of improvement of my skin depends on my age, skin type and condition, degree of sun/environmental damage, pigmentation levels, or acne/rosacea condition. _____.

I understand that this chemical treatment is expected to make the skin feel uncomfortable during the actual process but agree to inform the Aesthetician immediately if I have any concerns during the treatment and after I return home. _____.

For best results and minimizing possible reactions, I will be responsible for following a home care regimen given to me by my Aesthetician, including recognizing the importance of adhering to sunscreen and avoiding the sun/tanning booths and extreme weather conditions. I agree to use a moisturizer specifically recommended by my Aesthetician and I acknowledge that I have been informed of the possible negative reactions (intense erythema, welts, scabs, chemical burn) and the expected sequence of the healing process(dryness, irritation, redness, flaking and peeling of the skin).

If I may have additional questions or concerns regarding my treatment or suggested home care/post treatment care, I will consult my Aesthetician immediately _____. In the event of a highly negative reaction and the involuntary absence of my Aesthetician, I am responsible for contacting my Primary Care Physician to seek treatment and possible medication to treat adverse reaction_____.

Client Consent & Treatment Notes

I understand the potential risks and complications and have chosen to proceed with the treatment after careful consideration of the possibility of both known and unknown risks, adverse reactions, and limitations. I agree that this constitutes full disclosure, and that it replaces any previous verbal or written disclosures. I certify that I have read and fully understand the above paragraphs and that I have had sufficient opportunity for discussion to have any questions answered.

I, _____, have read and fully understand the below information and initialed each section. If I have any questions or concerns regarding my skin treatments during and after treatment, I will address these with my Aesthetician. I give permission to my Aesthetician,_____ _____, to perform the PROLINE chemical treatment we have discussed and will hold him/her harmless from any liability that may result from this treatment. I understand my Aesthetician will take every precaution to minimize or eliminate possible reactions such as blisters, sores, or other reactions as much as possible. I understand that, although rarely, permanent damage can occur such as but not only hypopigmentation or hyper-pigmentation.

Client/Guardian Name (printed) _____ Client/Guardian Name (signed)_____

Aesthetician (printed)_____ Aesthetician (signed)_____

Date_____

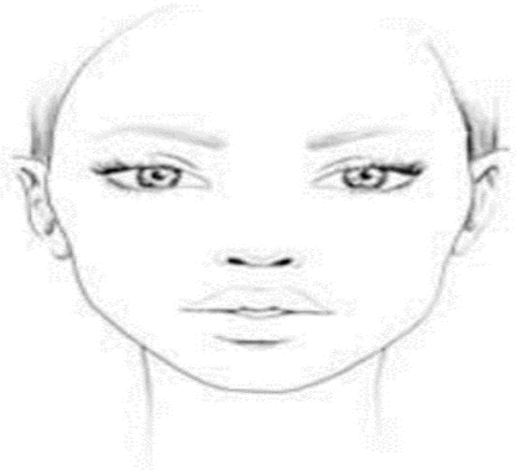
For Aesthetician

-Take Before Photo – Frontal & Both Sides. Do This with Every Treatment
-Explain/Provide hand out of What to Expect after Treatment for 1-14 days
-Show Portfolio of other Clients B/A Progress Pics & Cleared Skin After Series

Notes:

Treatment Plan:

Home Care Products:



Forehead: _____

_____

Eyebrows: _____

_____

Eyelids: _____

_____

Undereye: _____

_____

Cheeks: _____

_____

Marionette Lines: _____

_____

Lips: _____

_____

Chin: _____

_____

Neck: _____

_____