Chemical Peel Consent Form

This form, together, with the general information sheet, is designed to provide with information for making an informed decision regarding your chemical peel. If you have any questions, please do not hesitate to ask a member of our staff. While a chemical peel (or series of mild acid treatments) is effective in most cases, no guarantee can be made that a specific individual will benefit from the treatment.

- Prior to receiving this treatment, I have been candid in revealing any condition that may have a bearing on this procedure, such as, pregnancy, recent facial peels or surgery, allergies, tendencies to cold sores and fever blisters, use of Retin-A, Accutane or Hormones.
- I understand there may be some degree of minor discomfort, i.e., scratchiness, itchiness.
- I understand there are no guarantees to this procedure.
- I understand that to achieve maximum results, I will need several ongoing treatments and will need to use a daily product over a period of time.
- I understand that the possibility of irritation and redness exists and that I should notify my skin care professional when irritation persists.
- I will follow the home care program specifically designed for me without changing or adding any products without consulting with my skin care professional.
- I have read the enclosed consultation and understand the contents.
- I agree to all of the above to have this treatment performed on me and will follow all prescribed directions regarding post peel care.

My questions have been answered by the staff to my complete satisfaction. I accept the risks and complications of the procedure.

PRINT NAME: _____

SIGNATURE: _____ DATE: _____

Skin Care Questionnaire

Date: _____

Name: _____ Birth Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Referred by: _____

PERSONAL DATA:

Smoker: (circle one) *no yes* Pregnant: (circle one) *no yes*

Cosmetic surgery: (circle one) *no yes* If yes, when: _____ ___

Define procedure(s): _____

Medication: (circle one) *no yes* If yes, what kind(s)? _____

Any health problems? (circle one) *no yes* If yes, explain: _____

Any allergic reactions to medication? (circle one) *no yes* If yes, describe: _____

Do you have any allergies? (circle one) *no yes*

Do you suntan? (circle one) *no yes*

Do you use sunscreen? (circle one) *no yes*

Please name the brand of products you are currently using:

Cleanser: _____ Toner: _____

Moisturizer: _____ Scrub:_____

Mask: _____ Buff Puff: _____

Other: _____

Have you ever used Retin-A? (circle one) *no yes* If yes, what strength? _____

Have you ever been treated with Phenol or Trichloracetic acid? (circle one) *no yes*

Have you ever used Hydroquinone (skin lightener)? (circle one) *no yes*

Have you ever been on Accutane? (circle one) *no yes* If yes, when?_____

Have you ever had *herpes, hives, cold sores, fever blisters, keloids*? Circle all that apply

If yes, when? _____

How would you characterize your skin: (circle one) *Sensitive Rough Dry Oily/Acne-prone*

If you had one complaint about your skin, what would it be? _____

Describe your skin in three words: _____

Additional comments/concerns: _____

_____