

# BARE BEAUTY

l a s e r + s k i n s t u d i o

## patient profile

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_ Sex: \_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

### About you:

What is your hereditary background? (Check all that apply)

- Nordic
- Scandinavian
- Irish
- English
- Asian
- Mediterranean
- Hispanic
- Native American
- Middle Eastern
- African American
- Other: \_\_\_\_\_

Natural eye color: \_\_\_\_\_

Natural hair color: \_\_\_\_\_

Do you consider 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
- Rosacea
- Eczema
- Freckled
- Sun-damaged
- Melasma
- Hyperpigmentation
- 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?

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### Lifestyle:

Are you pregnant or lactating? (Please consult with your obstetrician. Only the **Oxygenating Trio®** , **Detox Gel Deep Pore Treatment** or **Hydrate: Therapeutic Oat Milk Mask** are appropriate.)

- Yes

No

Do you wear contact lenses? (**Remove contacts** if eyes are sensitive or if having microdermabrasion)

Yes

No

Do you currently have a sunburned/windburned/red face?

Yes

Why? \_\_\_\_\_

No

Are you in the habit of going to tanning booths? (If within the past 14 days, decline treatment. This practice should be discontinued due to increased risk of skin cancer and signs of aging.)

Yes

No

Do you participate in vigorous aerobic activity or sports?

Yes

What type? \_\_\_\_\_

No

Do you smoke or use tobacco?

Yes

No

What kind of work do you do? \_\_\_\_\_

On average, how many hours per week do you spend outdoors? \_\_\_\_\_

### Medical / Treatment history:

Do you currently use depilatories or wax? (Discontinue use five days pre- and post-treatment.)

Yes

No

Have you had a chemical peel or any type of procedure with a medical device?

Yes

No

Within the last 14 days?

Yes

What type? \_\_\_\_\_

No

Do you have regular collagen, Botox® or other dermal filler injections? (Peels should precede or follow injections by two days to prevent movement of the filler or stinging at the injection site.)

Yes

No

Have you recently had laser resurfacing or facial surgery?

- Yes
- No

Describe: \_\_\_\_\_

When? \_\_\_\_\_

Are you currently taking any medications, topical or otherwise?

(Tretinoin/Retin-A®/Renova®/Differin®/Tazorac®/Avage®/EpiDuo®/Ziana®)

- Yes
- No

Which one(s)? \_\_\_\_\_

For how long? \_\_\_\_\_

What strength? \_\_\_\_\_

(High percentages of certain ingredients may increase sensitivity. Discontinue use five days before and after treatment. Consult your physician before discontinuing use of any prescription.)

Have you undergone Accutane® therapy (isotretinoin)?

- Yes
- No

**(If you are currently using Accutane® therapy (isotretinoin), please consult with your dispensing physician.)**

(If you are no longer using Accutane® therapy (isotretinoin), it is OK to apply ONE layer of **Ultra Peel® I, Sensi Peel®, Advanced Treatment Booster, Oxygenating Trio®, Hydrate: Therapeutic Oat Milk Mask** or **Revitalize: Therapeutic Papaya Mask.**)

Do you develop cold sores/fever blisters?

- Yes                      Last breakout? \_\_\_\_\_
- No

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? \_\_\_\_\_

Have you ever used any other products that caused a bad reaction?

Yes

Describe: \_\_\_\_\_

No

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_

Clinician signature: \_\_\_\_\_ Date: \_\_\_\_\_

## consent form

Prior to receiving treatment, I have been candid in revealing any condition that may have bearing on this procedure, such as: pregnancy (if so, consult your physician prior to treatment), recent facial surgery, allergies, tendency to cold sores/fever blisters, or use of topical and/or oral prescription medications such as: tretinoin, Retin-A®, isotretinoin, Accutane®, Differin®, Tazorac®, Avage®, EpiDuo® or Ziana®.

I understand there may be some degree of discomfort such as stinging, pin-prickling sensation, heat or tightness.

I understand there are no guarantees as to the results of this treatment, due to many variables, such as: age, condition of skin, sun damage, smoking, climate, etc.

I understand I may or may not actually peel and that each case is individual. I understand that the amount of peeling does not correlate with degree of improvement.

I understand this treatment is a cosmetic treatment and that no medical claims are expressed or implied.

I understand that to achieve maximum results, I may need several treatments.

I understand that although complications are very rare, sometimes they may occur and that prompt treatment is necessary. In the event of any complications, I will immediately contact the physician/clinician who performed the treatment.

I agree to refrain from tanning in tanning beds or outdoors while I am undergoing treatment, and during the 14 days prior to and following the end of treatment. This practice should be discontinued due to the increased risk of skin cancer and signs of aging.

I understand that extended direct sun exposure is prohibited while I am undergoing treatment, and the daily use of sunscreen protection with a minimum SPF of 30 is mandatory.

