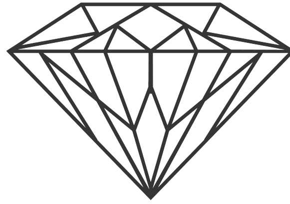

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Consent Form - Oncology Facial

Please answer the following questions so that your Skin Care Specialist may have a better understanding of your general health and lifestyle, thereby enabling your Skin Care Specialist to accurately analyze and assess your skin care needs.

Name: ____

Date: __________________

Address: ____

City: ___________________________________

State: _______________ Zip: _____________

Cell Phone: ________________________________

Date of Birth: _________________________

E-mail address:
____

Emergency Contact Name: ___________________________

Phone: _______________________

Dr's name: ______________________________________

Phone: _______________________

How did you hear about us?
____
____

Health History

What type of cancer do you have/had? ____________________

Date diagnosed _________________________

Chemotherapy? Yes / No Date started ____________________

Last dose taken _________________________

Radiation therapy? Yes / No Date started ___________________

Last treatment _________________________

Any other cancer therapy? Yes / No Explain

____

Surgery? ____

date/s _______________________________

Incision site? Yes or No - Located ______________________________

Port / PICC / Ommava / Central Line? Yes or No - Located

____

Lymph Nodes removed? Yes or No -

Located ____

Pain / Inflammation? Yes or No -

Located ____

Radiation Burns? Yes or No -

Located ____

Poor wound healing? Yes or No Explain

____

Dryness? Yes or No Explain

____

Rashes? Yes or No Explain

Peripheral Neuropathy? Yes or No Explain

Hand/Foot

Syndrome (PPE)? Yes or No Explain

Fatigue? Yes or No Explain

Shortness of breath? Yes or No Explain

Chills or Loss of balance? Yes or No Explain

Claustrophobia? Yes or No Explain

Have you been under the care of a physician, dermatology or other medical professional within the past year? Yes / No, Explain

Any recent surgery, including plastic surgery? Yes / No
Explain

Are you currently taking any other medications? Yes / No
If yes, please list

Any questions and concerns? Skin or Scalp
Explain

Any allergic reaction to any ingredients in skincare or medication? Yes or No
Please list

Have you had reaction to aspirin or fish? Yes or No

Please list any other known allergies:
____

Please circle if you are presently experiencing or have experienced any of the following:
Skin Cancer - Dermatitis - Keloid Scarring - Acne - Rosacea - Broken Capillaries - Treatment Reactions -

Hypopigmentation - Hyperpigmentation.

Home care

What skin care products are you currently using at home?
Cleanser ____

Exfoliants/Scrubs
____

Toner ____

Mask ____

Moisturizer
____

SPF ____

Specialty Products
____
____

I have acknowledged that all of the information provided by me is true and correct to the best of my knowledge. I understand that some skin conditions may require more than one treatment and home care products to achieve the result desired. Results cannot be guaranteed due to individual skin type(s) and condition(s). I understand I need to sign this waiver prior to every treatment provided, with ANY changes pertaining to the above questionnaire.

Client Name (Print):
____

Client (Signature):
____

Date: ___________________________________

Chelsea Alex- owner/esthetician

Licensed in NH & ME

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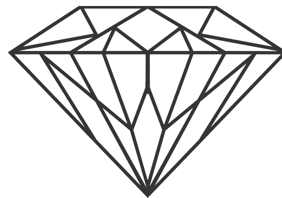

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