

Health Questionnaire
(Facials, Peels, Microdermabrasion, and/or Clarifusion)

Name: _____

Age: _____

Are you currently under the care of a physician for a specific condition? Yes No
If Yes, list reason(s).

List all current medications:
(Include ointments and creams prescribed by a physician.)

Check all that apply:

- | | | |
|----------------------------|----------------------------|---|
| Acne | Eczema | Sinus Infections |
| Auto Immune Disease | Hepatitis | Skin Cancer |
| Blood Thinners | High Blood Pressure | Uncontrolled Diabetes |
| Dermatitis | Low Blood Pressure | Vascular Lesions |
| Facial/Oral Surgery | Pace Maker | Viral Lesions
(Herpes Simplex) |
| | Pregnant/Nursing | |

Please explain any items circled above if indicated.

Check products if you are currently using them on areas to be treated.

- Acutane** **Alpha or Beta Hydroxy Products** **Retin-A** **Salicylic Acid**

Others: _____

Please list any previous facial treatments and date.
(i.e., chemical peel, microdermabrasion, laser resurfacing.)

What do you hope to achieve from this treatment?

Signature

Date

Informed Consent

Name: _____

- I understand that an abrasive sensation or stinging may occur during the treatment.
- I understand that possible side effects include but are not limited to: breakout, peeling, tightness, mild to extreme redness, wind-burn sensation, dry skin, flaking skin, and/or lightening or darkening of the skin.
- I understand that the results of this treatment may vary due to conditions: such as age, condition of skin, sun damage, damage due to smoking, climate, etc.
- I understand that the number of treatments is dependent on skin type and condition, and that completely following the advised program will lead to the best results.
- I understand that this treatment is a cosmetic treatment and that no medical claims are expressed or implied.
- I understand that blemishes and/or cold sores may result after this treatment.
- I understand that waxing, collagen injections and Botox injections should be avoided for 10 ~14 days before or after this treatment.
- I understand that direct sun exposure, including tanning booths, is prohibited while I am undergoing treatment and that the use of daily sun block protection (minimum SPF 20) to the area treated is mandatory.
- I have not had a chemical peel or microdermabrasion treatment of any kind within 14 days of this treatment, whether the treatment was performed at this location or any other location.
- I understand that I am to discontinue all AHA's, Glycolics, Retin-A, Renova or any exfoliating products for up to 72 hours post treatment.
- I understand that rare side effects may result from facials, peels, microdermabrasion, and clarifusion such as: red marks, rashes, hyperpigmentation, superficial burns, and scarring.

I hereby agree to all of the above and agree to have this treatment performed on me. I further agree to follow all post-care instructions. Prior to receiving any treatment, I have been candid in revealing any condition that may have bearing on this procedure. I am over 18 years of age. (Parental consent required for minors.)

Patient Signature

Date

Parent/Guardian Signature

Date

Pure Radiance Day Spa Staff Signature

Date