VI PEEL

PATIENT INTAKE FORM

Patient Intake Form

Name: _____ Age: _____ DOB: _____ SEX: ___ M ___ F Date: _____

Address: _____ City: _____ ST: _____ Zip: _____

Circle all skin concern(s) that you are seeking improvement upon.

PIGMENT AGING ACNE ROSACEA OTHER

Are you pregnant or breastfeeding? YES NO If yes, you are contraindicated for a chemical peel.

Do you have permanent makeup? YES NO Do you wear contacts? YES NO

Have you recently had facial or body waxing or used at home depilatories? YES NO

Do you currently have sunburn or wind burned skin? YES NO **If yes, you are contraindicated.**

Do you have extended outdoor plans in the next 7 days? YES NO

Do you plan to participate in vigorous exercise in the next 72 hours? YES NO

Have you had any active skin care treatments in the past 21 days? YES NO **If yes, how long ago?**

List all topical products applied in the last 7 days _____

List all prescription medications currently taken and in the past two weeks. _____

(Note: Patient MUST be off Accutane for 3-6 months prior to peeling) _____

Have you recently undergone any surgery or laser treatments in the area to be treated? YES NO

If yes, please provide detail _____

Do you receive injectables? (Botox, fillers) YES NO Do you develop cold sores? YES NO

Do you have any known allergies or sensitivities? (Please list)

Describe your ethnic background (English, Hispanic, Italian, German, Asian, Native American, African American, etc.)

_____

How would you describe your skin? SENSITIVE NORMAL RESILIENT

Phone Number: _____

Email Address: _____