Patient Completed
Medical History Form

Date of Initial Visit: _____Esthetician: _____
Client Name: _____ Occupation: _____
Address: _____
City, State & Zip: _____
Daytime Phone: _____Cell Phone: _____

Age: □ 21 years & under □ 21-30 years □ 31-40 years □41-50 years □over 50 years

The following profile must be completed for all clients participating in a PowerPeel® microdermabrasion treatment. This form has been created for us to obtain adequate information about your past medical history, in order for the esthetician to evaluate the condition of your skin. All information is kept confidential.

1. Briefly describe your cosmetic concerns and what results you would like to achieve:
   _____
2. What made you consider PowerPeel® microdermabrasion and how did you hear about us?
   _____

Client History:

1. Are you currently ,or within the last year, under a physician's care? □ Yes □ No
2. Have you undergone any surgery in the last nine months? □ Yes □ No If Yes, please specify:
   _____
3. Have you had any of these health problems in the past or present?
   □Cancer □ Heart problems □ Tuberculosis □ Rosacea
   □Diabetes □ Hormone imbalance □ Hepatitis □ Herpes/ prone to cold sores
   □Epilepsy □ Thyroid □ Liver disease □ HIV or other immune deficiency disorder
4. List any medication and vitamins that you take regularly: _____
5. Are you allergic to any medications? □ Yes □ No If Yes, please specify: _____
   Other allergies: _____
6. Do you smoke? □ Yes □ No Do you exercise regularly? □ Yes □ No
   Have you ever had a chemical peel? □ Yes □ No Do you get regular sleep? □ Yes □ No
   Do you use Retin-A? □ Yes □ No Do you wear contact lenses? □ Yes □ No
   Have you used Accutane? □ Yes □ No Do your wounds heal slowly? □ Yes □ No
7. Do you have any special skin problems on your face? □ Yes □ No If Yes, please specify: _____
8. What types of skin care products are you currently using:
   □ Soap □ Toner □ Masque □Other _____
   □Cleanser □Moisturizer □Scrub/peel? _____
9. **Female:**
   Are you taking oral contraception? □ Yes □ No
   Are you pregnant or trying to become pregnant? □ Yes □ No
   Are you lactating? □ Yes □ No
10. **Male:**
    Do you experience irritation from shaving? □ Yes □ No
    Do you experience ingrown hair? □ Yes □ No

Skin Conditions:

1. Do you experience breakthrough oil shine during the day? □ Yes □ No
2. Do you experience breakthrough breakout regularly? □ Yes □ No
   If so, where? : _____
3. Do you ever experience: □Flakiness □Tightness □Dryness
4. Do you use a sunscreen? □ Yes □ No □ Occasionally Do you burn easily? □ Yes □ No
5. Does your skin have reddening tendencies? □ Yes □ No

I confirm that the answers I have given are correct and that I have not withheld any information that may be relevant to my treatment.

Client's Signature:_____