

CONSENT FORM

MegaPeel® Microdermabrasion Treatment

Prior to receiving this treatment, I have been candid in revealing any condition that may have a bearing on this procedure, such as, pregnancy, recent facial peels or surgery, allergies, tendencies to cold sores and fever blisters, use of Retin-A, Accutane or Hormones.

I understand there may be some degree of minor discomfort, i.e., scratchiness, itchiness.

I understand there are no guarantees to this procedure.

I understand that to achieve maximum results, I will need several ongoing treatments and will need to use a daily product over a period of time.

I understand that the possibility of irritation and redness exists and that I should notify my skin care professional when irritation persists.

I will follow the home care program specifically designed for me without changing or adding any products without consulting with my skin care professional.

I have read the enclosed consultation and understand the contents.

I agree to all of the above to have this treatment performed on me and will follow all prescribed directions regarding post peel care.

PRINT NAME: _____

ADDRESS: _____

SIGNATURE: _____ DATE: _____

Skin Care Questionnaire

Date: _____

Name: _____

Birthdate: _____

Address: _____

City: _____

State: _____

Zip: _____

Home Phone: _____

Work Phone: _____

Referred by: _____

PERSONAL DATA:

Smoker: (circle one) *no* *yes*

Pregnant: (circle one) *no* *yes*

Cosmetic surgery: (circle one) *no* *yes* If yes, when: _____

Define procedure(s): _____

Medication: (circle one) *no* *yes* If yes, what kind(s)? _____

Any health problems? (circle one) *no* *yes* If yes, explain: _____

Any allergic reactions to medication? (circle one) *no* *yes* If yes, describe: _____

Do you have any allergies? (circle one) *no* *yes*

Do you suntan? (circle one) *no* *yes*

Do you use sunscreen? (circle one) *no* *yes*

Please name the brand of products you are currently using:

Cleanser: _____

Toner: _____

Moisturizer: _____

Scrub: _____

Mask: _____

Buff Puff: _____

Other: _____

Have you ever used Retin-A? (circle one) *no* *yes* If yes, what strength? _____

Have you ever been treated with Phenol or Trichloroacetic acid? (circle one) *no* *yes*

Have you ever used Hydroquinone (skin lightener)? (circle one) *no* *yes*

Have you ever been on Accutane? (circle one) *no* *yes* If yes, when? _____

Have you ever had *herpes*, *hives*, *cold sores*, *fever blisters*, *keloids*? Circle all that apply

If yes, when? _____

How would you characterize your skin: (circle one) *Sensitive* *Rough* *Dry* *Oily/Acne-prone*

If you had one complaint about your skin, what would it be? _____

Describe your skin in three words: _____

Additional comments/concerns: _____
