



Patient Completed Medical History Form

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

Age: 21 years & under 22-30 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: _____