

RIVER CITY REJUVENATION

Client's Name: _____ DOB: _____ Age: _____ Date: ____/____/____

Address: _____

City: _____ State: _____ Zip: _____ E-mail address _____

Would you like to receive e-mails from us? (specials, news, etc.) _____

Phone Home/Work & Cell: _____

A referral is the greatest compliment. Please let us know who referred you to River City Rejuvenation.

Referred by: _____

Are you currently under the care of a physician for your skin? Y N

If yes, why? _____

Have you ever seen a dermatologist or other physician for your skin? Y N

If yes, when and why? _____

Have you previously had:

Chemical Peel? Y N Type of peel _____ Date _____

Laser Resurfacing, Dermabrasion, Phototherapy or Microdermabrasion? Y N

Type/Depth _____ Date _____ Facial surgery? Y N

Procedure _____ Date _____

Have you done any aggressive exfoliation to your skin in the last 2 weeks? Y N

If yes, explain: _____

What skincare products do you use frequently? _____

How do you presently care for your skin? _____

Are you cleansing your face morning and evening? Y N

Do you use a washcloth or sponges on your face? Y N

Are you taking Accutane®? Y N If yes, what is the dosage and frequency? _____

Have you ever taken Accutane®? Y N If yes, last taken on? _____

What topical medications do you use or have you used? Retin-A® ____ Hydroquinone ____

Other: (this includes topical antibiotics, OTC acne remedies, Hydrocortisone, etc.) _____

Please list any oral medications you currently take: _____

(This includes hormones, birth control pills, antibiotics, tranquilizers, anti-depressants, diuretics, etc.) Please list any nutritional supplements you take: _____

Have you ever been diagnosed with an infectious disease such as (HIV positive, Hepatitis A or Hepatitis B?) Y N

HYPERSENSITIVITY AND SKIN FRAGILITY:

Have you ever had a skin allergy or sensitivity? (Rash, irritation, peeling, swelling, hives, etc.)

Y N to: cosmetics ____ fabrics ____ other: (i.e. latex, etc.) _____

Do you have any known allergies to anything? Y N

If yes, please list all allergies: (this includes medications, aspirin, food, etc.) _____

Do you "flush" or "appear reddened" easily when you eat spicy food, drink alcohol, get angry, go in the sun, etc.) Y N Please explain: _____

FREE RADICAL EXPOSURE:

Do you smoke? Y N How much? _____
Do you consume alcohol? Y N How much? _____
Do you have a healthy diet? Y N List any dietary concerns _____
Do you exercise? Y N How much? _____ What type? _____
Do you take vitamins? Y N Multi-Vitamins: _____ Antioxidants _____
Do you drink water? Y N How many glasses per day? _____

FOR WOMEN ONLY:

Do you have regular periods? Y N
Are you going through menopause? Y N
Are you pregnant or lactating? Y N
Have you ever been pregnant? Y N
Are you trying to become pregnant? Y N
If yes, during pregnancy did you ever experience hyperpigmentation or a "pregnancy mask"? Y N

PIGMENTATION (Fitzpatrick scale):

How do you tan?

I Burn ___ II Usually Burn ___ III Sometimes Burn ___
IV Rarely Burn ___ V Never Burn-"Brown" ___ VI Never Burn-"Black" ___

Pigmentation: Even ___ Uneven ___ Birthmark ___ Pregnancy Mask ___

What is your Ethnicity and Race (heritage)? _____

VASCULARITY (telangiectasia or broken capillaries):

Nose area _____ Cheek area _____ Chin area _____ Forehead _____ Entire face _____

ACNE:

Do you have any history of acne or periodic breakouts? Y N
Pimples _____ White heads _____ Blackheads _____
Enlarged Pores _____ Acne Scars _____ Cysts _____ Flakiness _____

Do you only experience breakout during or around your menstrual cycle? Y N

Do you always have a pimple or some type of breakout? Y N

FACIAL WRINKLES: Deep Wrinkles _____ Crows Feet _____ Fine Lines _____

Have you been treated with Botox _____ Fillers _____

If yes, date of last treatment: _____

Skin Type:

Does your skin ever flake or feel tight and dry?

Frequently _____ Occasionally _____ Very Rarely _____

Is your skin ever shiny a few hours after cleansing?

Frequently _____ Occasionally _____ Very Rarely _____

How often do you experience blackheads or blemishes?

Frequently _____ Occasionally _____ Very Rarely _____

How noticeable are your pores? Very _____ T-zone _____ Not Very _____

ABILITY TO HEAL:

Does your skin appear fragile or burn easily?

Y N If yes, please explain: _____

Do you have any problems healing from a cut or burn?

Y N If yes, please explain: _____

Do you have any health problems?

Y N If yes, please explain: _____

Do you ever use depilatories or waxes on your face?

Y N If yes, when last used? _____

Have you ever had a "cold sore"?

Y N If yes, when was your last cold sore? _____

SUN HISTORY AND LIFESTYLE:

Do you work inside? Y N

Occupation: _____

Are your hobbies done mostly outside? Y N

Hobbies: _____

In the past (including childhood) did you live in a sun belt? Y N

Where did you live? _____

In the past have you neglected to use a sunscreen when outdoors? Y N

Do you ever use tanning beds? Y N

If yes, when? _____

Do you currently wear a sun protection product all day, everyday? Y N

Are you willing to wear a sun protection product all day, everyday? Y N

HAVE YOU OR ANY MEMBER OF YOUR FAMILY HAD SKIN CANCER?

Y N If yes, who? _____ An anatomical location of the lesion(s): _____

ARE YOU CURRENTLY SEEING A PHYSICIAN FOR ANY REASON? Y N

If yes, please explain: _____

HOW DO YOU WANT TO IMPROVE YOUR SKIN?

1.) _____

2.) _____

SKIN CONDITION:

OS/A (Oily Skin/Acne) _____ S/IS (Sensitive skin/Intolerant) _____

D/SD (Dry/Severely Dry) _____ PAS (Prematurely Aged Skin) _____

WHAT SPECIFIC AREAS SO YOU WANT TO TREAT?

Neck _____ Face _____ Chest _____ Back _____ Other _____

DO YOU WEAR CONTACT LENSES? Y N

Client Signature:

Date:

Esthetician's Signature:

Date:

In the event that you and your esthetician decide to do one of the three peels: (micro peel, micro peel plus or LHA, it is important to understand that even though the chances are slim, there could always be adverse effects. I _____ (int.) understand that while the benefits of the peels are to smooth fine lines, help with skin discoloration, reduce the appearance of acne scars and environmental damage to the skin, there could be risks in rare cases, that may occur in connection with this particular procedure.

The foregoing list is not intended to be a complete or exhaustive list of all possible problem or complications, which may arise as a result of the Clinical procedure. Should one or more of the foregoing complications arise, please notify us immediately.

Discomfort: is generally minimal and subsides after a sort duration

Swelling: is unusual, but if it occurs, it will be minimal. Swelling subsides in a few hours to a few days

Reddening: or a red discoloration may persist anywhere from a few days to several weeks

Demarcation: is a difference in color, texture, pigmentation that may occur at the junction between the treated and non-treated skin areas. This is unusual with epidermal Clinical procedures

Existing Blemishes: or moles, blood vessels (telangiectasias), freckles and sun spots may become more obvious and darker since layers of dead skin have been removed

Eye Injury: caused by chemical getting into the eye, scarring and vision disturbances may occur. Protective safety goggles are recommended to be worn by you, the client, while chemicals are being used during all Clinical procedures

Scarring: is very unusual, but may occur

Pigmentation: is rare and usually temporary. Possible permanent changes in the color of the skin could occur

Milia: may occur, but will usually disappear quickly

Infection: is extremely unlikely, but may happen. An outbreak of herpes may occur in effected individuals (if you are prone to cold sores, ask your physician for medication)

Signature