

Ocean Med Spa
Facial Peel
915 SE Ocean Blvd #5
Stuart, Florida 34994

Name: _____ Date of Birth: / ____ / ____

Home Ph: _____ Cell Ph: _____

Address: _____ City: _____

State: _____ Zip: _____ Email: _____

How did you hear about us: _____

Emergency Contact: _____ Ph: _____

Your Skin

Yes No Do you have allergies? If yes, which ones: _____

Yes No Have you had a chemical peel in the last 6 months?

Yes No Do you experience skin breakouts?

Yes No Do you experience oily shine throughout the day?

Yes No Do you ever experience a burning, itching sensation on your skin?

Yes No Do you ever experience flakiness and/ or tightness?

Yes No Do you use SPF on your face? If so which one: _____

Yes No Do you sunbathe or use tanning beds?

Yes No Do you burn easily in moderate sunlight?

Yes No Do you blush easily when nervous?

Yes No Do you have a tendency to redness?

Yes No Do you suffer from sinus problems?

Yes No Have you ever experienced a reaction to any skin care products? If so which ones: _____

Yes No Within the last year have you been under the care of a dermatologist or other physicians care? If so what for? _____

Yes No Within the last 2 years have you undergone any surgeries? If yes, please specify: _____

Yes No Have you had any health problems past or present? If yes, please specify: _____

Yes No Do you have any special skin problem pertaining to your face or body? If yes, please explain: _____

Yes No Do you smoke?

What skin care products are you currently using?

Soap Cleanser _____ Toner _____

Exfoliator _____ Moisturizer _____

Masque _____ Eye Products _____

Other _____

Yes No Do you currently use Accutane, Retin A, Renova, Adapalene or any other prescription skin care products? If yes, please list:

Yes No Are you currently using any products that contain the following ingredients, please circle all that apply:

Glycolic Acid, Lactic Acid, Exfoliating Scrubs, Hydroxy Acids, Vitamin A Derivatives

Yes No Have you ever had chemical peels, microdermabrasion or any resurfacing treatments? If yes, how long?

How much water do you consume daily? _____

How many alcoholic beverages do you consume weekly? _____

What are your skin care goals? _____

Ocean Med Spa

915 SE Ocean Blvd · Stuart, FL 34996

Peels

Client Informed Consent Form

To the CLIENT: you have a right to be informed about your condition and its treatment, so that you may decide whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is to allow you to make an informed decision to give, withhold, or consent to treatment.

1. I voluntarily request that Eileen Villa perform the Peel procedure. I acknowledge having been informed that this cosmetic procedure is intended to remove surface layers of the skin to improve the vitality of the skin.
2. Peels, despite their high levels of efficiency and safety, and not free of side effects. Erythema (redness) and edema (swelling) of the treated areas can occur. This usually subsides within a few hours, but can last up to seven days or longer. Irritation, itching, and/or a mild burning sensation, similar to sunburn, may occur within 48 hours of treatment.
3. It is important to use sunscreen with 25 SPF or greater when exposed to the sun.
4. I understand complications can include white heads, cold sores, infection, scarring, numbness, and permanent discoloration, particularly in people with dark skin.
5. No guarantee, warranty, or assurance has been made to me as to the results that may be obtained. I am aware that follow-up treatments may be necessary for desired results. Most patients require a number of treatments over several months and gradual results occur over this time. Clinical results will vary per patient. I agree to adhere to all safety precautions and regulations during the treatment. No refunds will be given for treatments received.

I understand and agree that all services rendered to me are charged to me directly and that I am personally responsible for payment.

The nature and purpose of the treatment have been explained to me. I have read and understand this agreement. All of my questions have been answered to my satisfaction and I consent to the terms of this agreement. Alternative methods of treatment and their risks and benefits have been explained to me and I understand that I have the right to refuse treatment.

_____ I consent to having m photograph taken before, during and after treatment. Although my name will not be associated with these photographs, they may be used to educate other patients.

Client's Name (Please print)

Client's Signature

Date