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