CHEMICAL PEEL
CLIENT INFORMATION /MEDICAL FORM

FerrariSKN
By Gina Ferrari

Full Name

Birthdate

Address

Phone #

City

State/Province

Zip/Postal Code

Emergency Contact/Phone#

Sign me up for Email/Text alerts
Yes No

Email

Are you pregnant? Yes_____ No_____ Are you a lactating? Yes_____ No_____
(If yes to either of the above questions, only the Oxygenating Trio or Detox Gel is appropriate).
Do you wear contact lenses? Yes_____ No _____ (Please remove contacts if eyes are sensitive)
Do you have any permanent make-up? Yes _____ No _____
If yes, list location of permanent makeup:_____
Do you currently have a Sunburn Windburn Red Face? Please explain: _____
Do you go to tanning beds regularly? Yes _____ No _____
Do you currently use or receive Depilatories, Sugaring or Waxing Treatments? Yes _____ No _____
(If yes, please discontinue use 7 days prior and post treatment).
Ary you applying any topical medications at this time? Yes _____ No _____
If yes, please list: _____
Are you currently using any topical Retinoid prescriptions (Retin-A, Renova, Differin, Tazorac, or Avage? Yes _____No _____
If yes, please fill out: Prescription name: _____What strength:_____
How long: _____ (Please discontinue use 5-10 days prior to treatment and 5-10 days after treatement)
***Please consult your physician before discontinuing use of any prescription.
Are you currently using Accutane? Yes _____ No _____ If yes, for how long? _____
(If using Accutane, please consult physician prior to treatment. It's ok to apply ONE layer of Sensi Peel, Ultra Peel II, Esthetique Peel, or Oxi Trio to skin that has been treated with Accutane).
Have you had a chemical peel or any type of facial procedure with a medical device? Yes _____ No _____
(Peels should follow injections by 2-5 days to prevent movement of filler)
Have you had any facial surgery? Yes _____ No _____ If yes, please describe: _____
_____ Date of surgery:_____
Have you had any laser resurfacing? Yes _____ No _____ If yes, please describe: _____
_____ Date of laser resurfacing:_____
Do you smoke or vape? Yes _____ No _____
Do you develop cold sores/fever blisters? Yes _____ No _____ If yes, when was last breakout:_____
Are you sensitive to alcohol-based products? Yes _____ No _____