CHEMICAL PEEL

CLIENT INFORMATION /MEDICAL FORM (CONTINUED)

FerrariSKN
By Gina Ferrari

Are you allergic/sensitive to: (please check all that apply)

☐ Milk ☐ Apples ☐ Citrus ☐ Grapes ☐ Aloe Vera ☐ Aspirin ☐ Perfumes ☐ Latex ☐ Hydroquinone ☐ Mushrooms

Do you have any other allergies? Yes _____ No _____ If yes, please list all allergies: _____

_____

Have you ever used any skin care products that caused an allergic/bad reaction? Yes _____ No _____ If yes, please describe:_____

Are you currently taking any medications (Antibiotics may increase sensitivity) ? Yes _____ No _____

If yes, please list:_____

What is your hereditary background? _____

Natural Hair Color: ☐ Blonde ☐ Red ☐ Medium Brown ☐ Dark Brown ☐ Black ☐ White ☐ Gray/Silver

Natural Eye Color: ☐ Blue ☐ Green ☐ Hazel ☐ Light Brown ☐ Medium Brown ☐ Dark Brown

Skin Tone: ☐ Pale/White ☐ Light ☐ Medium ☐ Reddish ☐ Freckled ☐ Light Olive ☐ Medium Olive ☐ Dark Olive ☐ Light Brown ☐ Medium Brown ☐ Dark Brown ☐ Soft Black ☐ Black ☐ Sallow

Do you consider your skin: ☐ Sensitive ☐ Resilient ☐ Not Sure?

Describe your skin (check all that apply):

☐ Thick	☐ Acne	☐ Florid Cutaneous	☐ Patchy Dryness
☐ Thin	☐ Milia	☐ Rosacea	☐ Sallow
☐ Saggy	☐ Cysts	☐ Eczema	☐ Melasma
☐ Firm	☐ Breakouts	☐ Freckled	☐ Psoriasis
☐ Normal	☐ Acne Scarred	☐ Sun Damaged	☐ Hypopigmentation
☐ Dry	☐ Comedones/Blackheads	☐ Uneven/Blotchy	☐ Hyperpigmentation
☐ Combination	☐ Large Pores	☐ Mature	☐ Dehydrated
☐ Oily	☐ Small Pores	☐ Wrinkled	☐ Asphysiated
			☐ Telangiectasia/Broken Surface Capillaries

What is your daily skin care regimen?

_____

_____

What are the cosmetic improvements you would like to see on your skin?

_____

_____

Do you particopate in vigorous activities or sports? Yes _____ No _____

If yes, please explain:_____

What type of work do you do? _____

Do you have a pacemaker or any pins in bones? Yes _____ No _____