Client Information	
Name and Surname	
Mobile Number	
E-mail	
Birthday	

Medical Information

1. List any chronic medication.
   _____
   _____
2. List any medical conditions you have.
   _____
   _____
3. List any operations you have had in the last year.
   _____
   _____
4. List any vitamins and/ or supplements you take regularly.
   _____
   _____

Skin Information

1. List any Aesthetic procedures experienced in the past.
   _____
   _____
2. List anything you are allergic to.
   _____
   _____
3. Have you used Roaccutane or Retin-A in the past?
   _____
   _____
4. Do you burn easily during sun exposure?
   _____
   _____
5. Have you experienced any burning or stinging sensation on your skin in the last 3 months?
   _____
   _____
6. Do you suffer with redness?
   _____
   _____
7. How much alcohol do you consume weekly?
   _____
   _____

8. How much caffeinated beverages do you consume daily?

_____

_____

9. How much plain water do you consume daily?

_____

_____

10. Do you smoke?

_____

_____

11. Do you exercise?

_____

_____

12. Do you follow a restricted diet?

_____

_____

13. List all the skincare products you are currently using at home.

_____

_____

General

1. Are you pregnant or breast feeding? **Yes/ No**
2. Do you suffer from Epilepsy? **Yes/ No**
3. Do you have Diabetes? **Yes/ No**
4. Are you due for you menstrual cycle? **Yes/ No**
5. Rate your stress level (1- no stress, 5 - very stressed) _____
6. Do you suffer with fever blisters (cold sores)? **Yes/ No**
7. Do you have a Pacemaker? **Yes/ No**
8. Do you have any cardiac abnormalities? **Yes/ No**
9. Do you keloid scar? **Yes/ No**
10. Do you use blood thinning medication? **Yes/ No**
11. Are you prone to bruising? **Yes/ No**
12. Are you prone to bleeding? **Yes/ No**
13. Do you have any immune disorders? **Yes/ No**

Treatment Notes

Fitzpatrick Classification

Type	Additional Notes
1	
2	
3	
4	
5	
6	

Notes:

_____
_____
_____
_____

Peels

Date	Peel	Notes	Homecare