Grand River
Cosmetic Services

Skincare Assessment

Name: _____ DOB: _____

Personal History

Have you ever seen a physician or technician specifically for a skin problem or skincare? ☐ Yes ☐ No
If yes, when and for what reason? _____

Are you **currently** under any other physician's or technician's care for your skin? ☐ Yes ☐ No
If yes, detail reason (s): _____

Do you have any allergies or skin sensitivities? ☐ Yes ☐ No
If yes, list all allergies/skin sensitivities: _____

Do you currently take any **oral** medications (prescriptive pharmaceuticals)? ☐ Yes ☐ No
(includes Oral hormones, birth control pills, antibiotics, tranquilizers, diuretics, hypertension, etc.)
If yes, list all **oral** medications: _____

Do you use any **topical** medications (prescriptive pharmaceuticals)? ☐ Yes ☐ No
(includes Retin-A, Hydroquinone, Benzoyl Peroxide, Antibiotics, Metrogel, Efudex, Cortisone, etc.)
If yes, list all **topical** medications? _____

Have you ever taken an oral retinoid? ☐ Yes ☐ No
I currently take an oral retinoid: Date discontinued _____ Dosage/frequency used _____
I took an oral retinoid in the past: Date discontinued _____ Dosage/frequency used _____

Have you ever had a "COLD SORE"? ☐ Yes ☐ No
If yes, when was your last cold sore? _____

Do you ever use hair removal creams or waxes on your face ☐ Yes ☐ No
If yes, when last used? _____

For women only:

Are you trying to become pregnant? ☐ Yes ☐ No Are you in a fertility program? ☐ Yes ☐ No

Are you pregnant or lactation? ☐ Yes ☐ No Have you ever been pregnant? ☐ Yes ☐ No

If yes, during pregnancy did you ever experience hyperpigmentation or a "pregnancy mask"? ☐ Yes ☐ No

Skin Product History

Do you currently use skincare products as a daily regimen? ☐ Yes ☐ No
If yes, list products: _____

Have you done any aggressive exfoliation to your skin in the last 2 weeks? ☐ Yes ☐ No
If yes, explain type(s) of exfoliation: _____

Turn Over ↓

Skin Procedure History

Have you previously had any of these skin procedures (treatments)? ☐ Yes ☐ No If no, skin this section.

Microdermabrasion	☐ Yes ☐ No	Date of last procedure: _____
Chemical Peel(s)	☐ Yes ☐ No	Date of last procedure: _____
Phototherapy	☐ Yes ☐ No	Date of last procedure: _____
Laser Resurfacing	☐ Yes ☐ No	Date of last procedure: _____
Radiofrequency	☐ Yes ☐ No	Date of last procedure: _____
Dermabrasion	☐ Yes ☐ No	Date of last procedure: _____
Facial Surgery	☐ Yes ☐ No	Type of surgery(s)/date: _____

Other procedures/date? _____

Additional comments about above procedure(s): _____

Oily Skin or Acne

Any acne breakout? ☐ Blackheads ☐ Whiteheads ☐ Enlarged Pores ☐ Pustules ☐ Large pores ☐ Cysts

Do you have any history of acne or periodic breakout? ☐ Yes ☐ No If yes: ☐ Now ☐ In past?

Do you always have a pimple or some type of breakout? ☐ Yes ☐ No

Do you only experience breakout during or around your menstrual cycle? ☐ Yes ☐ No

Does your skin ever flake or feel tight and try? ☐ Frequently? ☐ Occasionally? ☐ Very rarely?

Is your skin every shiny (oily) a few hours after cleansing? ☐ Frequently? ☐ Occasionally? ☐ Very rarely?

How noticeable are your pores? ☐ Very ☐ T-zone only ☐ Not very noticeable

Sensitive and Intolerant or Dry Skin

Do you "flush or reddened" when eating spicy food, drink alcohol, angry or go in the sun, etc? ☐ Yes ☐ No

Does your skin ever get flaky or itch? ☐ Yes ☐ No If yes, is it seasonal or all the time? _____

Have you ever been diagnosed with Rosacea? ☐ Yes ☐ No If yes, when was the diagnosis made? _____

Do you have difficulty healing from a cut or burn? ☐ Yes ☐ No If yes, explain: _____

Have you ever had a keloid scarring? If yes, explain: _____

Prematurely Aged and/or Hyperpigmented Skin

Do you have facial wrinkles? ☐ Deep wrinkles ☐ Crows feet ☐ Fine lines ☐ Skin Laxity
Have you been treated with: ☐ Botox? ☐ Fillers? If yes, date of last treatment: _____
Do you work inside? ☐ Yes ☐ No Occupation: _____
Are your hobbies done mostly outside? ☐ Yes ☐ No Hobbies: _____
In the past (including childhood) did you live in a sun belt? ☐ Yes ☐ No If yes, where? _____
In the past have you neglected to use a sunscreen when outdoors? ☐ Yes ☐ No
Are you willing to wear a sun protection product all day, every day? ☐ Yes ☐ No
Do you ever use tanning beds? ☐ Yes ☐ No If yes, when? _____

Fitzpatrick Scale (how your skin reacts to sun exposure). How do you tan?
☐ I Burn ☐ II Usually Burn ☐ III Sometimes Burn
☐ IV Rarely Burn ☐ V Never Burn-"Brown" ☐ VI Never Burn-"Black"
Is your skin pigmentation (skin discoloration): ☐ Even ☐ Uneven ☐ Birthmark(s) ☐ Pregnancy Mask
What is your Ethnicity and Race (heritage)? _____

How Do You Want To Improve Your Skin?

1. _____
2. _____

What Specific Skin Areas Do You Want To Treat?

☐ Face ☐ Neck ☐ Chest Other: _____

Patient Signature:	Date:
Technician Signature:	Date:
M.D. Signature:	Date

Grand River
Cosmetic Services

Medical Skincare Informed Consent

Name: _____ DOB: _____ Today's Date: _____

The SkinCeuticals Pigment Balancing Masque, Micropeel or Micropeel Plus, hereinafter known as "Clinical Procedure(s)", is not a cure all epidermal treatment. However, for certain skin conditions, these Clinicial Procedure(s) can provide marked improvement in the appearance of one's skin. Therefore, it is very important that you have a thorough understanding of what a Clinical Procedure(s) can and cannot do for your particular skin condition. In addition, it is imperative that you acknowledge the potential risks associated with the administration of Clinical Procedure(s).

The foregoing list is not intended to be a complete or exhaustive list of all possible problems or complications, which may arise as a result of the clinical Procedure(s). Should one or more of the foregoing complications arise, please notify the physician's office immediately.

Discomfort is generally minimal and subsides after a short duration.

Swelling is unusual. If it occurs, it is minimal. Swelling subsides in a few hours to a few days.

Reddening or a red discoloration may persist anywhere from a few minutes to several days.

Demarcation is a difference in color, texture or pigmentation that may occur at the junction between the treated and non-treated skin areas. This is unusual with epidermal procedures.

Existing Blemishes or moles, blood vessels (telangiectasias), freckles and sun spots may become more obvious and darker since layers of dead skin have been removed.

Eye Injury caused by chemical getting into the eye, scarring and vision disturbances may occur.

Scarring is very unusual, but my occur.

Pigmentation is rare and usually temporary. Possible permanent changes in the color of the skin could occur.

Milia may occur, but will usually disappear quickly.

Infection is extremely unlikely, but may happen. An outbreak of herpes may occur in affected individuals (if you are prone to cold sores, as your physician for medication).

In General: Any and all risks and complications can result in additional surgery, hospitalizations, time off work and expenses to you. Early detection and treatment may minimize future complications.

Turn Over ↓

Before subjecting yourself to any Clinical Procedure(s), read carefully the following statements. After you have read each statement, please **initial** each respective statement in the space that has been provided.

_____ The Procedure(s) has been explained to me in detail by the provider / or member of the provider's staff. For Optimum results, I understand a homecare regimen is needed to enhance the results of a SkinCeuticals Peel.

_____ I understand the Procedure(s) is a skin rejuvenation treatment. I may need several administrations of this procedure in order to achieve my best results.

_____ I understand the Procedure(s) need not be administered by a physician. I also comprehend that, in addition to receiving training, any non-physician medical assistant (i.e., RN, LPN, Surgical Technician, Cosmetologist or Aesthetician who administers SkinCeuticals Peels has had her or his skills reviewed and endorsed by the supervising or attending physician.

_____ I understand that it is extremely important to strictly follow all homecare regimen instructions when striving for optimal results.

_____ I understand that if I experience any adverse side effects that appear to be attributable to my use of homecare regimen products, I would discontinue use of the products and notify the office.

I certify that I have read and understand ALL of the above. I have also discussed the same with the technician.

Patient Signature: _____ Date: _____

I certify that I have discussed ALL of the above with the patient and have offered to answer any questions regarding the Clinical Procedure(s), and I believe that the patient fully understands the explanations and answers.

Technician Signature: _____ Date: _____