

CHEMICAL PEEL CONSULTATION FORM

GENERAL INFORMATION

Full name: _____ Date of birth: _____

Address: _____

Phone: _____ Email: _____

What is your gender? Male Female Non-binary Other

Are you 18 years of age or over? Yes No

How did you hear about us? _____

Would you like to be added to our email list for specials and discounts? Yes No

MEDICAL INFORMATION

Please describe any specific skin concerns or areas you would like to target during the chemical peel treatment: _____

Are you pregnant? Yes No

Do you have any recent sunburn? Yes No

Do you have any active cold sores? Yes No

Have you had any chemical peels or facial laser treatments? (last 2 weeks) Yes No

Do you have any skin cancer history? Yes No

Have you used Accutane? (past 6 months) Yes No

Have you used or are on any blood thinners? Yes No

Other medical conditions: _____

SKIN HISTORY

History of skin conditions: _____

Previous facial treatments: _____

Allergies or sensitivities: _____

Current skincare routine: _____

Medications or supplements: _____

CHEMICAL PEEL CONSULTATION FORM

(continued)

SUN EXPOSURE AND TANNING

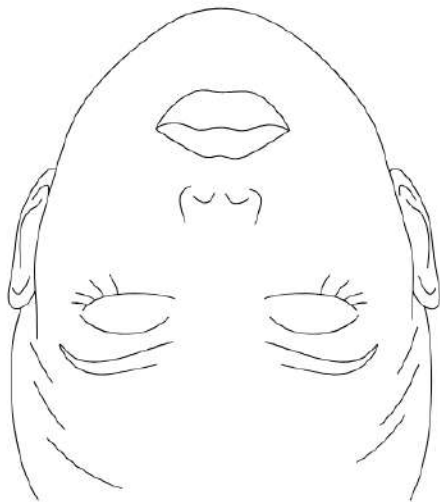
- Do you regularly engage in outdoor activities or spend time in the sun? Yes No
 Have you had any recent sunburns? Yes No
 Do you use tanning beds or self-tanning products? Yes No

PREVIOUS CHEMICAL PEEL EXPERIENCE

- Have you had a chemical peel before? Yes No
 If yes, please provide details (type of peel, strength, results, any complications):

Please describe what you hope to achieve with a chemical peel and any specific goals you have in mind:

SKIN DISORDERS/CONDITIONS



NOTES

Acne	A	Comedones	C	Thin	T
Asphyxiated	As	Milia	Mi	Warts	W
Breakout Activity	Br	Mole	Mo	Deep Lines	DL
Broken Capillaries	BC	Sensitivity/Redness	S/R	Hyperpigmentation	H+
Discoloration	D	Rosacea	R	Hypopigmentation	H-
Dilated Capillaries	DC	Scars	Sc	Photo Aging	A
Keloid	K	Skin Tags	ST	Psoriasis	Ps
Open Pores	OP	Spider Veins	SV	Pustules	Pu
Oily	O	Sunburn	Su	Papules	Pa