



CHEMICAL PEEL

Consultation Form

CLIENT INFORMATION

Name: _____ Date: _____

Occupation: _____ Age: _____ Female Male NB

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Your Occupation: _____

Emergency contact: _____ Phone #: _____

Would you like to be added to our email list for news and exclusive offers? Yes No

MEDICAL HISTORY

Do you have or have you had any of the following conditions? If yes, please select them:

- | | | |
|--|--|--|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Low blood pressure |
| <input type="checkbox"/> Arthritis / tissue disorder | <input type="checkbox"/> Herpes / Cold sores | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Open sores or lesions |
| <input type="checkbox"/> Dermatitis | <input type="checkbox"/> HIV | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Hyperpigmentation | <input type="checkbox"/> Rashes |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypopigmentation | <input type="checkbox"/> Rosacea |
| <input type="checkbox"/> Easily scar | <input type="checkbox"/> Immune disorder | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Infectious disease | <input type="checkbox"/> Seborrhea |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Irritated skin | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Heart condition | <input type="checkbox"/> Keloid scarring | <input type="checkbox"/> Warts |

Any other condition: _____

♀ Are you pregnant or nursing? No Yes

SUNRISE ESTHETICS

Sunrise Esthetics // 209-639-8916

Any known allergies? No Yes: _____

List any medications you take regularly, including vitamins, herbal supplements, aspirin:

Are you currently under a doctor's care? No Yes

If yes, please explain: _____

Have you ever been treated for cancer? No Yes

If yes, please explain: _____

Any previous surgeries, including plastic surgery? No Yes

If yes, please explain: _____

SKIN CARE

Please Check Current Products You Use:

- | | | |
|---|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> Eye Make-Up Remover | <input type="checkbox"/> Eye Cream | <input type="checkbox"/> Mask |
| <input type="checkbox"/> Cleansing Cream | <input type="checkbox"/> Day Cream | <input type="checkbox"/> Facial Scrub |
| <input type="checkbox"/> Facial Soap | <input type="checkbox"/> Night Cream | <input type="checkbox"/> Exfoliants |
| <input type="checkbox"/> Skin Toner/ Astringent | <input type="checkbox"/> Neck lotion | <input type="checkbox"/> Body Lotion |
| <input type="checkbox"/> Body Soap | <input type="checkbox"/> Hand cream | <input type="checkbox"/> Body Scrub |

SKIN HISTORY

- What is your skin type? Normal Oily Dry Combo Unsure
- Your exposure to the sun? Never Light Moderate Excessive
- What type of foundation do you wear? Liquid Cream Powder None
- How does your skin heal? Fast Slow Scars Pigments
- Do you burn easily in moderate sun? No Yes

SKIN CONCERNS

- | | | | |
|---|--|------------------------------------|--|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Dryness/Dull Skin | <input type="checkbox"/> Milia | <input type="checkbox"/> Sensitivity |
| <input type="checkbox"/> Blackheads | <input type="checkbox"/> Eczema | <input type="checkbox"/> Oily Skin | <input type="checkbox"/> Sun Damage |
| <input type="checkbox"/> Broken Capillaries | <input type="checkbox"/> Fine lines/Wrinkles | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Thin Skin |
| <input type="checkbox"/> Comedones | <input type="checkbox"/> Hyper pigmentation | <input type="checkbox"/> Redness | <input type="checkbox"/> Unwanted Hair |
| <input type="checkbox"/> Cherry Angioma | <input type="checkbox"/> Hypo pigmentation | <input type="checkbox"/> Rosacea | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Discoloration | <input type="checkbox"/> Keloids | <input type="checkbox"/> Scarring | _____ |

SKIN INFORMATION

Have you ever had chemical peel or any resurfacing treatments previously? No Yes

Have you had any facial or dermatology services in the past 30 days? No Yes

Do you have permanent or semi permanent makeup? No Yes

Do you currently have a sunburn? No Yes

Have you ever used acne medication? No Yes

If yes, when? _____ Which drug? _____

Have you used Retin-A, Renova, AHA's or Vitamin A derivative products in the last 3 months?

No Yes, please describe: _____

Have you received Botox, Restylane, or Collagen injections?

No Yes, please describe: _____

Are you currently using any products that contain the following ingredients?

- | | | |
|---|--|---|
| <input type="checkbox"/> Accutane | <input type="checkbox"/> Renova | <input type="checkbox"/> Any hydroxy acid products |
| <input type="checkbox"/> Adapalene | <input type="checkbox"/> Glycolic acid | <input type="checkbox"/> Retin-A |
| <input type="checkbox"/> Any exfoliating scrubs | <input type="checkbox"/> Lactic acid | <input type="checkbox"/> Vitamin A derivatives (i.e. Retinol) |

MEN ONLY

Do you suffer from ingrown facial hair? No Yes

Experience razor burn? No Yes

What is your current shaving system? Electric Wet shave

By signing below, you agree to the following:

I have completed this form truthfully and to the best of my knowledge. I agree to inform the technician of any changes in the above information. I agree to waive all liabilities toward Sunrise Esthetics, LLC, and any of their associates for any injury or damages incurred due to any misrepresentation of my health history.

Client Name (printed)

Client Name (signature)

Date

Esthetician (signature)

Date