SKIN FORMULAS

Chemical Peel

Consent Questionaire

Full Name(s):

Date of Birth:

Address:

Email:

Mobile:

Are you Male or Female? M F

Are you currently seeing your doctor for any medical conditions? Y N

Are you prone to cold-sores / lip herpes? Y N

Are you taking any medication? Please list: Y N

Have you or any members of your family had skin cancer? Y N

During pregnancy, did you get hyper pigmentation or masking? Y N

Do you have any allergies (including salicylic/aspirin, nut or latex)? Y N

Do you sunbathe or use sun beds? Y N

Have you ever had a skin allergy/reaction after a treatment? Y N

Are you planning a sun holiday in the next 6 weeks? Y N

Have you ever seen a dermatologist? Y N

Do you suffer from claustrophobia? Y N

Do you use any topical medications? Y N

Do you suffer from asthma? Y N

Have you undergone any cosmetic procedures? Y N

Do you wear contact lenses? Y N

Could you be pregnant, planning a pregnancy or breastfeeding? Y N

Do you undertake any exercise? Y N

Have you been diagnosed with HIV positive, AIDS or Hepatitis C? Y N

Do you smoke or live with anyone who smokes? Y N

Have you ever had chemotherapy / radiotherapy? Y N

What is your daily water intake? Y N

What is your current skincare regime? Please list all products you currently use on your skin.

Signature:

Date: