# MICRODERMABRASION SKIN TREATMENT

## *PATIENT INFORMATION AND HEALTH HISTORY*

**LAST NAME**_____ **FIRST NAME**_____

**ADDRESS**_____ **ZIP CODE**_____

**EMAIL ADDRESS**_____ **BIRTH DATE**_____

**PHONE**_____ **OCCUPATION**_____

**NEAREST RELATIVE NAME & PHONE**_____

**HAVE YOU EVER SEEN A DERMATOLOGIST FOR YOUR SKIN?** **Y** **N**

**ARE YOU TAKING ACCUTANE?** **Y** **N**

**HAVE YOUR EVER TAKEN ACCUTANE?** **Y** **N**

**IF YES WHEN?**_____

**WHAT TOPICAL MEDICATIONS DO YOU USE OR HAVE YOU USED?**

**RETIN-A** _____ **GLYCOLIC ACID** _____ **OTHER**_____

**WHAT ORAL MEDICATIONS DO YOU USE OR HAVE YOU USED?**

**ANTIBIOTICS**_____**HORMONES/BIRTH CONTROL**_____

**DIURETICS**_____**OTHER**_____

**HAVE YOU, OR ANYONE IN YOUR FAMILY, EVER HAD SKIN CANCER?** **Y** **N**

**IF YES, PLEASE LIST TYPE OF CANCER AND OTHER PERTINENT INFORMATION**

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# *VASCULARITY*

**BROKEN CAPILLARIES:**

**NOSE AREA_____ CHEEK AREA_____ CHIN AREA_____ FOREHEAD_____**

**ACNE:**

**DO YOU HAVE FREQUENT BREAK OUTS? Y N**

**PIMPLES_____ WHITEHEADS_____ BLACKHEADS_____ CYSTS_____**

**ENLARGED PORES_____ FLAKINESS_____ ACNE SCARS_____**

**SKIN CONDITION:**

**DRY_____ OILY_____ TIGHTNESS_____ FLAKINESS_____UNREMARKABLE_____**

**ANY SPECIAL SKIN PROBLEMS?_____**

**WHAT AREAS WOULD YOU LIKE TREATED?**

**FACE_____ NECK_____ CHEST_____ FOREARMS_____ OTHER_____**

- **I UNDERSTAND THAT MICRODERMABRASION MUST BE DONE REGULARLY IN ORDER TO ACHIEVE OPTIMAL RESULTS.**
- **I UNDERSTAND THAT IT IS EXTREMELY IMPORTANT TO STRICTLY FOLLOW ALL HOME CARE INSTRUCTIONS WHEN STRIVING FOR OPTIMAL RESULTS.**
- **I UNDERSTAND THAT IF I EXPERIENCE ANY ADVERSE SIDE EFFECTS THAT APPEAR TO BE ATTRIBUTED TO MY USE OF HOME CARE PRODUCTS THAT I NEED TO DISCONTINUE USE OF THESE PRODUCTS AND NOTIFY THE HEALTH AND STYLE INSTITUTE.**
- **I AGREE TO UNDERGO MICRODERMABRASION TREATMENT.**

**PATIENT SIGNATURE_____DATE_____**