THE

GOODFACE

Patient Profile

Name:_____DOB:_____
Address:_____
City:_____State:_____Zip:_____
Phone:_____Email:_____

About you:

- What is your hereditary background? (circle all that apply) Caucasian / Nordic / Scandinavian / Hispanic / Native American / Middle Eastern / African American / Other _____
- Natural eye color:_____
- Natural hair color:_____
- Do your consider your skin (circle the best option): Sensitive / Resilient / Unsure
- Describe your skin (circle all that apply): Normal / Dry / T-Zone / Combination / Thick / Thin / Saggy / Firm / Oily / Acne / Comedones / Blackheads / Milia / Cysts / Breakouts / Acne-scarred / Large pores / Small pores / Psoriasis / Rosacea / Eczema / Freckled / Sun-damaged / Melasma /Hyperpigmentation / Hypopigmentation / Uneven / Blotchy / Mature / Wrinkled / Patchy dryness / Sallow / Dehydrated / Lacking moisture / Asphyxiated / Telangiectasia / Broken surface capillaries
- What are the changes you'd most like to see in your skin?

_____
_____

Lifestyle:

- Are you pregnant or lactating? YES NO
  (**Please consult with your OB.** Only the **Oxygenating Trio**, **Detox Gel Deep Pore Treatment** or **Hydrate: Therapeutic Oat Milk Mask** are appropriate.)
- Do you wear contact lenses? YE S NO
  (**Remove contacts** if eyes are sensitive or if having microdermabrasion.)
- Do you currently have a sunburned/windburned/red face? YES NO
  Why?_____
- Are you in the habit of going to tanning booths? YES NO
  (If within the past 14 days, decline treatment. This practice should be discontinued due to increase risk of skin cancer and signs of aging.)
- Do you participate in vigorous aerobic activity or sports? YES NO
  What type?_____
- Do you smoke or use tobacco? YES NO
- What kind of work do you do?_____
- On average, how many hours per week do you spend outdoors?_____

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Medical / treatment history:

- Do you currently use depilatories or wax? YES NO
  (Discontinue use 5 days pre and post-treatment.)
- Have you had a chemical peel or any type of procedure with a medical device? YES NO
  Within the last 14 days? YES NO
  What type?_____
- Do you have regular collagen, Botox, or other dermal filler injections? YES NO
  (Peels should precede or follow injections by two days to prevent movement of the filler or stinging at the injection site.)
- Have you recently had laser resurfacing or facial surgery? YES NO
  Describe:_____
  When?_____
- Are you currently taking any medications, topical or otherwise?
  (Tretinoin / Retin-A / Differin / Tazorac / Avage / EpiDuo / Ziana)
  Which one(s)?_____
  For how long?_____
  What strength?_____
  (High percentages of certain ingredients may increase sensitivity. Discontinue use five days before and after treatment. Consult your physician before discontinuing use of any prescription.)
- Have you ever undergone Accutane therapy (isotretinoin)? YES NO
  (**If you are currently using Acutane therapy (isotretinoin), please consult with your physician.**)
  (If you are no longer using Accutane therapy (isotretinoin) it is OK to apply ONE layer of **Ultra Peel I, Sensi Peel, Ultra Peel II, Esthetique Peel, Oxygenating Trio, Hydrate: Therapeutic Oat Milk Mask or Revitalize: Therapeutic Papaya Mask.**)
- Do you develop cold sores/fever blisters? YES NO
  Last breakout?_____
- Are you allergic/sensitive to (circle all that apply) milk / apples / citrus / grapes / aloe vera / aspirin / perfumes / latex / hydroquinone / mushrooms? YES NO
  Other allergies?_____
- Have you ever used any other products that caused a bad reaction? YES NO
  Describe:_____

Patient Signature:_____Date:_____

Clinician Signatire:_____Date:_____

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