

Client Information

Name: Date:

Address:

Phone: Email:

DOB:

It is essential that you have had a patch test a minimum of 24 hours prior to your peeling treatment, to ensure you don't have any allergic responses.

Please confirm that you have received your patch test 24 hours prior to having a peeling treatment

Patch test completed by:

Date patch test completed:

Client Signature:

Health History

Please tick where applicable if you have any of the following conditions:

- | | |
|---|--|
| <input type="checkbox"/> Kidney / liver disease | <input type="checkbox"/> Prescription Strength Vitamin A for last 6 months |
| <input type="checkbox"/> Significant immunosuppression | <input type="checkbox"/> Scleroderma / vascular disease |
| <input type="checkbox"/> Use of antibiotics for last 6 months | <input type="checkbox"/> Pregnant or nursing mums |
| <input type="checkbox"/> Ehlers-Danlos Syndrome | <input type="checkbox"/> Heart disease / blood pressure |
| <input type="checkbox"/> Allergy to aspirin | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Metal plates or pins | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Active bacterial, viral or fungal infections | |

Health History

Please tick where applicable if you have any of the following conditions:

- | | | |
|-------------------------------------|---|--|
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Rosacea | <input type="checkbox"/> Pigmentation |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Thread Veins | <input type="checkbox"/> Dry Skin |
| <input type="checkbox"/> Dermatitis | <input type="checkbox"/> Moles | <input type="checkbox"/> History of cold sores |
| <input type="checkbox"/> Acne | <input type="checkbox"/> Sensitive Skin | <input type="checkbox"/> Sun Damage |

Precautions

Are you allergic or ever had any adverse reactions to:

- | | | |
|--------------------------------------|-----------------------------------|--|
| <input type="checkbox"/> Medications | <input type="checkbox"/> Alcohol | <input type="checkbox"/> Shampoo |
| <input type="checkbox"/> Cosmetics | <input type="checkbox"/> Clothing | <input type="checkbox"/> Hair dye |
| <input type="checkbox"/> Foods | <input type="checkbox"/> Soap | <input type="checkbox"/> Perfumes |
| <input type="checkbox"/> Jewellery | <input type="checkbox"/> Skincare | <input type="checkbox"/> Other: <input type="text"/> |

Have you taken any medication for a skin condition in the past? YES NO
If yes, please list details:

Are you currently taking any medications? YES NO
If yes, please list details:

Have you had any medical / health problems in the last 12 months? YES NO
If yes, please list details:

Are you pregnant or planning a pregnancy? YES NO

Have you received any injectable treatments (ie. Botox) in the last 24 hours? YES NO

Lifestyle:

Have you recently had any change in your diet, lifestyle or beauty regime? YES NO

Pre Chemical Peel Contra-indications that indicate the peel should NOT be performed;
(Please tick where appropriate)

- | | |
|---|--|
| <input type="checkbox"/> Inflamed acne cyst | <input type="checkbox"/> Active herpes |
| <input type="checkbox"/> Recent Retin-A use | <input type="checkbox"/> Recent depilation (48 hours) |
| <input type="checkbox"/> Roacutane use | <input type="checkbox"/> Open cuts in the area |
| <input type="checkbox"/> Irritated or damaged skin | <input type="checkbox"/> Sunburned skin |
| <input type="checkbox"/> Severe physical or mental stress | <input type="checkbox"/> Allergy to Medik8 homecare products |

Please note facial masks, manual +AHA / BHA exfoliators and enzymatic peels should not be used 48 hours prior to receiving a Medik8 Superficial Level 1 or Jessner Peel. Microdermabrasion, laser resurfacing and other facial treatments such as chemical peels, botox, skin fillers, IPL and plastic surgery should be completely healed.

Skin indications for the treatment:
(Please tick where appropriate)

- | | |
|--|---|
| <input type="checkbox"/> Acne and / or acne scarring | <input type="checkbox"/> Facial erythema |
| <input type="checkbox"/> Blocked pores / follicles | <input type="checkbox"/> Photo damage |
| <input type="checkbox"/> Dry, dehydrated skin | <input type="checkbox"/> Dull skin |
| <input type="checkbox"/> Fine lines & Wrinkles | <input type="checkbox"/> Improve skin texture |



BEAUTIFUL SKIN FOR LIFE

Medik8 Pre Treatment Homecare Regime:

Please confirm that you have been using Medik8 skincare for two weeks prior to this treatment and list which products you have been using regularly.

I have re-read the Consent Form and no skin indications, contra-indications have changed since my last visit. There has been no change to my health.

The skin care specialist has explained to me the above indications and contraindications of the Medik8 treatment to be performed on my skin, which I fully understand. I agree that a skincare specialist can perform this series of treatments. I understand that a mild redness and / or irritation may occur. This is a temporary reaction that will subside. I understand that I must wait 24 hours after each treatment (or longer until redness and/or irritation has completely subsided) before resuming the use of Medik8 home care products that contact AHAs, BHAs or Vitamin A. I understand that to obtain maximum results from the peels, I must have a series of treatments and use in conjunction with a Medik8 home care program. I understand that due to the variable nature of the human skin, no guarantee can be made to me regarding the results of this treatment.

CLIENT'S SIGNATURE

PRINT NAME

DATE