Confidential Skin Health History

NAME_____

DATE_____

Please answer the following confidential questions so that we may have a better understanding of your general health and lifestyle, thereby enabling us to accurately analyze and assess your skin care needs.

PERSONAL INFORMATION: Age_____ Date of Birth ____ / ____ /____

Address _____City _____ State ____ Zip _____

Home Phone _____ Mobile _____ Best time to reach AM PM

Email _____ Are you a smoker? Yes No

List all medications taken _____

Allergies _____

Are you currently under the care of a physician? Yes No
If yes, for what condition(s)?_____ Are you pregnant? Yes No

Please circle any of the following you have been treated for:
Skin Disease Acne Cold Sores High Blood Pressure Diabetes Cancer Hormone Therapy

Your daily stress level is: Mild/Low Medium/Average High/Intense

How much water do you drink a day?_____ How often do you exercise?_____

Do you have any metal implants in your body? Yes No If yes, where? _____

Ethnic Background _____Occupation _____

YOUR SKIN:

On a scale of 1 to 10 (1 = Horrible, 10= Fantastic), please rate how you feel about the overall look of your skin_____

How often do you wear facial sunscreen? Everyday Occasionally Only when I'm outside

If you go in the sun without sunscreen, how often will you burn?
Always Most of the Time Sometimes Rarely Burn Very Rarely I never Burn

When was your last sun burn?_____ Use of tanning beds: Daily Once a week Occasionally Never

Please list any cosmetic procedures you have had in the last 12 months _____

What skin care line are using? _____

Describe your daily skin care routine: _____

What is the most important improvement you would like to see in your skin_____

Do you receive any of the following procedures regularly?
Waxing Facial Injections Microdermabrasion Chemical Peels Other_____

I understand the information I have provided above is true and correct. I also understand that all information stated is strictly confidential and will not be shared outside of this facility due to HIPPA regulations.

Signature _____Date_____

Mapping Skin Rejuvenation

(IN OFFICE USE)

NAME_____**DATE**_____

SKIN CARE SPECIALIST_____

#1 CONCERN:_____**AGE:**_____

Skin Type_____Condition(s)_____

Fitzpatrick Type_____ Glogau Classification_____ Lira GPS Level_____

CURRENT HOME CARE PROGRAM:

PRODUCT	DRUGSTORE	DEPT STORE	PROFESSIONAL	RX
Cleanser				
AM Moisturizer				
AM UV Protection				
Pigment Treatment				
Topical Acne Medication				
Internal Acne Medication				
AHA Product				
Retin-A/Topical Prescription				
Exfoliator				
PM Hydrating/TX Crème				

HOME CARE PROGRAM RECOMMENDATIONS:

AM	PRODUCT	PM	PRODUCT
Step 1		Step 1	
Step 2		Step 2	
Step 3		Step 3	
Step 4		Step 4	

PROFESSIONAL TREATMENT PLAN:

TREATMENT #	RECOMMENDED TREATMENT	SCHEDULE DATE
1	Baseline Treatment:	
2		
3		
4		
5		
6		

NOTES/SAMPLES GIVEN:

_____

_____

_____

_____

Skin Care Specialist's Signature_____**Date** _____

Progress Notes

NAME_____

DATE	NOTES

Photo Dermatology Analysis

(IN OFFICE USE)

NAME_____ **AGE**_____

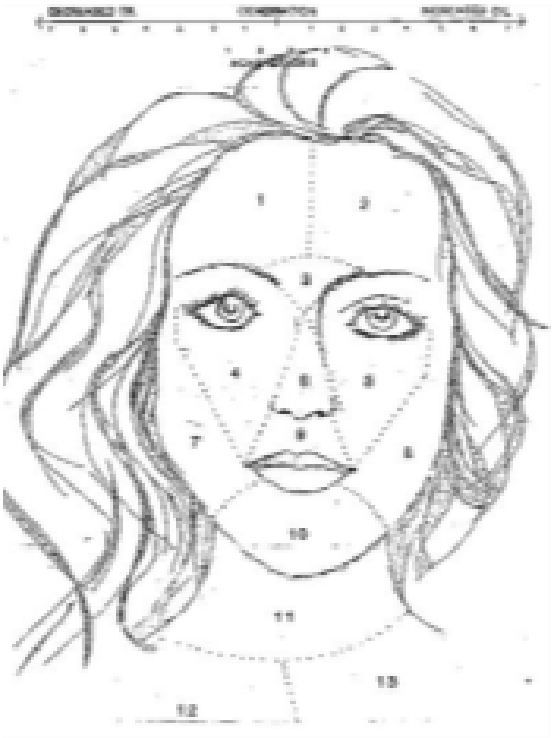
Treatment Date _____Treatment Performed _____

Prior Cosmetic Procedures _____

Fitzpatrick Type _____ Glogau Classification_____ Lira GPS Level_____

Sub-Dermis Thickness: Thin Medium Thick

Patch Test Performed: Yes No



FINE LINES & WRINKLES:

Wrinkle Assessment: Mild Average Moderate Severe

Elastosis Assessment: Mild Average Moderate Severe

PIGMENTATION:

Photo Damage: Mild Average Moderate Severe

Pigment damage initiated from:

Sun Tanning Booth Surgery
Acne Trauma Hormonal/Pregnancy

ACNE

Grade: I II III IV

Lesions Count: Right side _____ Left side _____

Lesions Identified:

Open Comedones_____ Papules_____
Closed Comedones_____ Pustules_____
Nodules_____ Cysts _____

SENSITIVITY

Rosacea Stage: I II III IV N/A

Telangiectasia: Mild Average Moderate Severe
Location(s) _____

Hypersensitive to touch? Yes No Skin Visibly Peeling? Yes No Open Wounds? Yes No

NOTES:

_____

_____

_____

_____

_____

_____

SKIN CARE SPECIALIST:_____**DATE**_____

Fitzpatrick Skin Type Evaluation

NAME_____

DATE_____

Please answer the questions below. Circle the appropriate response to each of the items to arrive at a total score.

Genetic Disposition					
Score:	**0**	**1**	**2**	**3**	**4**
What is the color of your eyes?	Light blue, Gray, Green	Blue, Gray or Green	Blue	Dark Brown	Brownish Black
What is the **natural** color of your hair?	Sandy Red	Blond	Chestnut/Dark Blond	Dark Brown	Black
What is the color of your skin? (non exposed areas)	Reddish	Very Pale	Pale with Beige Tint	Light Brown	Dark Brown
Do you have freckles on unexposed areas?	Many	Several	Few	Incidental	None
					Total Score for Genetic Disposition: _____

Reaction to Sun Exposure					
Score:	**0**	**1**	**2**	**3**	**4**
What happens when you stay in the sun too long?	Painful redness, blistering, peeling	Blistering followed by peeling	Burns sometimes followed by peeling	Rarely Burns	Never Burns
To What degree do you turn brown?	Hardly or not at all	Light color tan	Reasonable tan	Tan very easy	Turn dark brown quickly
Do you turn brown within several hours after sun exposure?	Never	Seldom	Sometimes	Often	Always
How does your face react to the sun?	Very sensitive	Sensitive	Normal	Very Resistant	Never had a problem
					Total Score for Reaction to Sun Exposure: _____

Tanning Habits					
Score:	**0**	**1**	**2**	**3**	**4**
When did you last expose your body to sun (or artificial sunlamp/tanning cream)?	Over 3 months ago	2-3 months ago	1-2 months ago	Less than a month ago	Less than 2 weeks ago
Do you expose the area to be treated to the sun?	Never	Hardly ever	Sometimes	Often	Always
					Total Score for Tanning Habits: _____

TOTAL SCORE	FITZPATRICK TYPE
0-7	I
8-16	II
17-25	III
25-30	IV
Over 30	V-VI

This will confirm your skin type which will be reviewed at time of consultation.

YOUR TOTAL SCORE:_____

Informed Treatment Consent

NAME_____

TREAMENT_____**DATE**_____

The instructions and guidelines provided in this informed consent should be followed by all individuals receiving a Professional Resurfacing Treatment.
Please read and initial after each paragraph acknowledging that you have read and understood all of the information presented.

PROFESSIONAL RESURFACING TREATMENT

1. This Professional Resurfacing Treatment is a superficial peel designed to improve the texture and appearance of your skin. Your participation in your treatment will determine the outcome. It is important that you strictly adhere to all instructions that your treatment specialist has provided. _____
2. No guarantee is expressed or implied as to the precise results, peeling times, or discomfort. _____
3. Depending on the treatment, you may experience some temporary redness, stinging, or warm flushing. During the next few hours, you may experience some tightening of the skin which may last for several days. _____
4. For most individuals, a light flaking begins within 48 hours. It is impossible to pre-determine how much peeling will occur. _____
5. Dark spots may appear darker before shedding off. _____
6. Depending on the treatment, the shedding process usually subsides within 2-7 days. _____
7. Lack of flaking or peeling is NOT an indication that the treatment was unsuccessful. If you do not notice actual peeling, you are still receiving all the benefits of your treatment such as improvement of skin tone, texture, and appearance of fine lines and hyperpigmentation. There are a number of reasons why some people may not experience peeling such as severe sun damage, having peels regularly with short intervals between treatments, and frequent use of Retin-A, Retinol, or AHAs. _____
9. Depending on the treatment performed and your individual skin health, the following reactions may occur in some individuals: Prolonged redness, irritation, flakiness, dryness, sensitivity, and in rare instances severe allergic reactions. _____

INDIVIDUALS WHO SHOULD NOT BE TREATED

1. A Professional Resurfacing Treatment SHOULD NOT be performed on people with active cold sores or warts, skin with open wounds, sunburn, excessively sensitive skin, dermatitis or inflammatory Rosacea in the area to be treated, or an autoimmune disease. _____
2. You should not have a Professional Resurfacing Treatment if you have a history of allergies, rashes, other skin reactions, cancer, or may be sensitive to any components of this treatment. _____
3. This treatment is not recommended if you have taken Accutane (or its generic form) within the past year, or received chemotherapy or radiation therapy. _____
4. With the exception of Lira Clinical's Beta-C Plus and Pumpkin Plus Definer with PSC treatments, this treatment should not be administered to pregnant or breastfeeding (lactating) women. _____

*Inform your treatment specialist if you have any of the above concerns, a history of herpes simplex, or are allergic to aspirin. _____

PRE-TREATMENT GUIDELINES

Unless otherwise instructed to do so by your treatment specialist:

1. One week prior to treatment avoid waxing, electrolysis, Laser Hair Removal, prescription retinoids/retinoid-like compounds (Retin-A, Renova, Differin, Tazorac), products containing Retinol, AHAs, BHAs, Benzoyl Peroxide, or any exfoliating products that may be drying or Irritating on the area to be treated. _____
2. Individuals who have medical cosmetic facial procedures must wait until skin sensitivity completely resolves before having a Professional Resurfacing Treatment. _____

POST TREATMENT GUIDELINES

It is crucial to the health of your skin and success of your treatment that these guidelines be followed:

1. It is imperative that you use the prescribed Lira Clinical BIO Recover Kit to heal and protect the skin which includes mandatory daily sun protection. _____
2. Avoid direct sun exposure for at least 48 hours. _____
3. Your skin may be more sensitive after your treatment so avoid strenuous exercise for at least 24 hours. _____
4. Do not pick or pull the skin. _____
5. When cleansing, do not scrub or use a wash cloth. _____
6. Wait until all flaking and peeling is complete before returning to your regular home care routine or having additional professional treatments. _____
7. Immediately notify your treatment specialist of any concerns. _____

CONSENT

I hereby give my consent & authorization, and voluntarily release_____ from any claims implied or stated that I have or may have in the future with this treatment, regardless of result. I am stating that the treatment and precautions above have been explained to me in detail and that I fully understand. If I am under the care of a physician, I have discussed the treatment plan with my physician for prior approval.

SIGNATURE:_____**DATE:**_____