PATIENT PROFILE

Alumier MD

Name: D.O.B: Gender:

Business name:

Address:

City: State: Zip code:

Phone number: Email address:

ABSOLUTE CONTRAINDICATIONS

	YES	NO
Are you currently using or have you used Accutane (isotretinoin) in the last six months?	☐	☐
Are you pregnant or nursing/lactating?	☐	☐
Do you have a cold sore today (herpetic breakout)?	☐	☐
Do you have any allergies? If yes, please list:	☐	☐
Do you have a skin infection/open wound in the treatment area?	☐	☐
Are you allergic to Aspirin (acetylsalicylic acid)?	☐	☐
Are you presently undergoing cancer treatment?	☐	☐
Do you have an autoimmune illness?	☐	☐

RELATIVE CONTRAINDICATIONS

	YES	NO
Have you had a chemical or enzyme peel within the last 14 days?	☐	☐
Have you had laser hair removal within the last 14 days?	☐	☐
Have you had a photofacial treatment within the last 14 days?	☐	☐
Have you had radio frequency skin tightening treatments within the last 14 days?	☐	☐
Have you had a microdermabrasion treatment within the last 14 days?	☐	☐
Have you had waxing, threading, or any other form of hair removal in the last 7 days?	☐	☐
Have you had Botox in the last 7 days?	☐	☐
Have you had any dermal filler injections in the last 7 days?	☐	☐
Have you been exposed to The Sun or used a tanning bed in the last 3 weeks?	☐	☐
Are you currently using any sunless tanning products?	☐	☐
Are you using any prescription or non-prescription retinoids (eg. retinol, Retin-A®, Tazorac®)?	☐	☐
Have you used any AHA/BHA skincare products in the last 7 day s?	☐	☐
Are you using any prescription topical medications at this time?	☐	☐
Do you wear contact lenses?	☐	☐
Do you have permanent make up?	☐	☐
Do you participate in aerobic physical activity?	☐	☐
Have you ever had a cold sore?	☐	☐
Have you ever used any skincare products that caused an adverse reaction?	☐	☐

What is the ethnic background of your parents?

What are the skin concerns that you would like us to help you with?

Do you have any medical issues?

☐ I consent to this data being collected and in the event of an adverse reaction, I consent to the clinic passing this information to AlumierMD for further advice

Patient signature: Date:

Professional signature: Date: