PATIENT PROFILE

Alumier MD

Name	D.O.B	Gender
Business name		
Address		
City	County	Post code
Phone number	Email address	

ABSOLUTE CONTRAINDICATIONS

	Yes	No
Are you currently using or have you used Roaccutane 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?	☐	☐

RELATIVE CONTRAINDICATIONS

Have you had a chemical 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 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 in the last 3 weeks?	☐	☐
Have you used a tanning bed in the last 3 weeks?	☐	☐
Are you currently using and sunless tanning products?	☐	☐
Are you using an prescription on non-prescription retinoids (eg, retinol, Retin-A®, Tazorac®)?	☐	☐
Are you using and AHA/BHA skin care products?	☐	☐
Are you using and prescription topical medications at this time?	☐	☐
Do you wear contact lenses?	☐	☐
Do you have permanent makeup?	☐	☐
Do you participate in aerobic physical activity?	☐	☐
Have you ever had a cold sore?	☐	☐
Have you ever used any skin care products that have caused and adverse reaction?	☐	☐

If yes, which ones? .....

What is the ethnic background of your parents? .....

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

☐ 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:**