CRYO
Health Recovery
Restore. Revitalize. Rejuvenate.
CRYOTHERAPY

CHEMICAL PEEL WAIVER

NAME: _____ DOB: _____

PHONE/CELL PHONE: _____ EMAIL:_____

EMERGENCY CONTACT: _____ FOR MINORS (GUARDIAN):_____

THE FOLLOWING INFORMATION WILL BE USED TO HELP PLAN SAFE & EFFECTIVE FACIAL SESSIONS EACH TIME YOU VISIT US. Your personal information is for CryoHealth Recovery use only and will not be shared with any person or entity outside CryoHealth Recovery. IT IS IMPORTANT YOU ANSWER ALL QUESTIONS TO THE BEST OF YOUR KNOWLEDGE AND HONESTY. THANK YOU.

Describe your skin (circle all the apply): Normal / Dry / T-Zone / Combination / Thick / Thin / Saggy / Firm / Oily / Acne / Comedones /Blackheads / Milia / Cysts / Breakouts / Acne-scarred / Large pores / Small pores / Rosacea / Eczema / Freckled / Sun-damaged / Melasma / Hyperpigmentation / Hypopigmentation / Uneven / Blotchy / Mature / Wrinkled / Patchy dryness / Sallow / Psoriasis / 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? ☐ No ☐ Yes
(Please consult with your obstetrician. Only the Oxygenating Trio ®, Detox Gel Deep, Pore Treatment or Hydrate: Therapeutic Oat Milk Mask are appropriate.)

• Do you wear contact lenses? ☐ No ☐ Yes
(Remove contacts if eyes are sensitive)

• Do you currently have a sunburned/windburned/red face? ☐ No ☐ Yes
Why? _____

• Have you used tanning bed in past 14 days? ☐ No ☐ Yes

• Do you participate in vigorous aerobic activity or sports? ☐ No ☐ Yes
What type? _____

•Do you smoke or use tobacco? ☐ No ☐ Yes

• Do you spend a lot of time outdoors? ☐ No ☐ Yes

Medical Treatment/History:

• Have you currently used depilatories, waxed, had laser hair removal or electrolysis? ☐ No ☐ Yes
(Discontinue use five days pre- and post-treatment.)

• Have you had a chemical peel or any type of procedure with a medical device? ☐ No ☐ Yes
Within the last 14 days? ☐ No ☐ Yes
What type? _____

• Do you have regular collagen, Botox® or other dermal filler injections? ☐ No ☐ Yes
(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? ☐ No ☐ Yes
Describe _____
When? _____
• Are you currently taking any medications, topical or otherwise? ☐ No ☐ Yes
(Tretinoin/Retin-A®/Renova®/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)? ☐ No ☐ Yes
(If you are currently using Accutane® therapy (isotretinoin), please consult with your dispensing 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? ☐ No ☐ Yes
Last breakout? _____
• Do you have herpes simplex or warts in the area to be treated? ☐ No ☐ Yes
• Are you allergic/sensitive to (circle all that apply) milk / apples / citrus / grapes / aloe vera / aspirin / perfumes / latex / hydroquinone / mushrooms? ☐ No ☐ Yes
If any other allergies, what? _____
• Have you ever used any other products that caused a bad reaction? ☐ No ☐ Yes
Describe _____.

Contraindications to chemical peels?

Chemical peels should be avoided if any of the following conditions are present:
• Active cold sores, herpes simplex or warts in the area to be treated
• Wounded, sunburned or excessively sensitive skin
• Accutane use within the last year
• History of recent chemotherapy or radiation therapy
• Allergies to aspirin
• Women who are pregnant or actively breastfeeding
• Patients with Vitiligo
• Patients with a history of autoimmune disease (such as rheumatoid arthritis, psoriasis, lupus, multiple sclerosis etc) or any condition that may weaken their immune system

Patient Signature: _____ Date: _____.

Clinician Signature: _____ Date: _____.