KAROL A GUTOWSKI, MD, FACS
AESTHETIC SURGERY
CERTIFIED BY THE AMERICAN BOARD OF PLASTIC SURGERY
MEMBER AMERICAN SOCIETY OF PLASTIC SURGEONS

CONSENT for FACIALS

Patient Name: Date:

Skin Conditions (Please select one or more)

_____Superficial Wrinkles, Fine Lines
_____Acne/Acne Prone / Rosacea
_____Hyper-pigmentation (sun or brown spot)

Please answer the following questions:

- Do you have any specific skin care problems/allergies pertaining to your face or body? _____
- What skin care products do you currently use? _____ _____
- Have you had a chemical peel, microdermabrasion, laser or any resurfacing treatments? If so, what/when was your last treatment(s)? _____ _____
- Do you use acne medication? _____ What kind? _____
- Are you taking Accutane? _____ Have you taken it in the past and if so, when? _____
- Are you applying Retina-A? _____ A derivative of Retina-A? _____ If yes, what is the name of the product and when have you taken it last? _____
- Do you burn easily? _____ Do you wear SPF on a daily basis? _____
- Do you experience an oily shine during the day? _____
- What are your skin care goals?_____ _____ _____

During the procedure if I experience any discomfort I will immediately inform the esthetician so that the products/techniques can be modified. I understand that a facial should not be construed as a substitute for medical examination, diagnosis and treatment and that estheticians are not qualified to perform, diagnose, prescribe, or treat any illness. I agree to keep the esthetician updated as to any changes in my medical history and understand that there shall be no liability on the esthetician's part should I fail to do so. I understand that the Licensed Esthetician reserves the right to refuse to perform treatments on anyone whom he/she deems to have a condition for which facial treatment are contraindicated.

Patient (Print Name)	Signature	Date
Esthetician (Print Name)	Signature	Date