



Lexington Plastic Surgery

Wax Consult Sheet

Date: _____

Name: _____ Date of Birth: _____

Address: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____

Email: _____

Employer: _____ Occupation: _____

How did you hear about us? _____

1) Have you used any Alpha Hydroxy Acid (AHA) or Glycolic products in the past 48-72 hrs? NO YES

2) Are you using Retin-A, Renova or Accutane? NO YES Specify: _____

3) Are you using any other skin thinning products and/or drugs that thin the blood? NO YES

Specify: _____

4) Are you exposed to the sun/tanning beds on a daily basis or are you considering spending more time in the sun soon? NO YES

Specify: _____

5) Are you a diabetic? NO YES

6) Do you bruise easily? NO YES

7) Are you currently taking any medications? NO YES

If so, please list: _____

8) When is your menstrual cycle due? _____ (We ask this, only because you are more sensitive to waxing just before your period/caffeine/pregnancy/alcohol)



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Please note that waxing can have certain side effects such as skin removal, redness, swelling, tenderness, etc.

I have read the above information and have given an accurate account of the questions and if I have concerns, I will address these with my Esthetician. I give my permission to my Esthetician to perform the waxing procedure we have discussed and will hold her harmless from any liability that may result from this treatment. I understand that my Esthetician will take every precaution to minimize or eliminate negative reactions as much as possible.

Client Signature: _____ Date: _____