



Client Profile-Medical History The Medical Spa of St. Louis

Name: _____ Date of Birth: _____ Today's Date: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Cell/Alt. Phone: _____
E-Mail Address: _____ How did you hear about us or who referred you?: _____

Have you ever had or have been treated for: (Circle all that apply):

Severe Headaches	Skin Rash/Disease	Heart Trouble	Cancer
Diabetes	High Blood Pressure	Bleeding Problems	Epilepsy
Allergy/Hay Fever	Shortness of Breath	Tuberculosis	Asthma
Varicose Veins	Phlebitis of Vein	Back Problem/Pain	Tendonitis
Mitral Valve Prolapse	Dizziness/Fainting Spells	Eye Injury/Disease	Neuritis
Drug/Alcohol Addiction	Bone/Joint Deformity	Head Injury	Aids
Swollen/Painful Joints	Ankle/Feet Swelling	Arthritis	

List other diseases or illnesses you have had: _____

Primary Physician: (Name and Telephone): _____

Pharmacy Name and Telephone Number: _____

List all prescription and non-prescription medication you are currently taking or have taken in the last 7 days: _____

Do you smoke: Y/N Live with a smoker?: Y/N Primary Care Physician: _____

Pharmacy Name and Phone Number: _____

Are you Pregnant? Y/N Due Date: _____ Are you currently lactating?: Y/N

Do you wear contacts?: Y/N

Previous Cosmetic Procedures (Circle all that apply):

Facials/Peels	Electrolysis	Depilatories	Microdermabrasion
Laser Resurfacing	Dermal Filler Injections	Botox/Dysport	Waxing
Facial/Cosmetic Surgery			

Describe type, frequency and reaction(s): _____

Allergies:

Are you allergic/sensitive to? (Circle all that apply):

Lidocaine	Adhesives	Latex	Aspirin	Perfumes	Milk
Hydroquinone	Mushrooms	Apples	Grapes	Citrus	Eggs
Aloe Vera	Alcohol Based Products				

List any allergies to medications: _____

Have you ever used any products that caused a bad reaction: Y/N

If yes, describe: _____



Have you seen a Dermatologist or other Physician for your skin?: Y/N

If yes, describe: _____

Have you ever had a skin allergy or sensitivity? (Rash, Irritation, Peeling, Swelling, Hives, etc)? If yes, describe: _____

Describe Your Skin (Circle all that apply):

Thick Thin Loose Firm Freckled Normal Dry Oily
Mature Wrinkled Uneven Pigmentation Rosacea Eczema Psoriasis Sun Damaged
Acne

Describe your ethnic background: _____

Do you consider yourself sensitive to touch or pain? Y/N Do you redden or flush easily when you eat spicy food, drink alcohol, get angry, go in the sun, etc.?: Y/N

Skin Tone (Circle your choice): Pale/White Light Medium Reddish Freckled
Light Olive Medium Olive Dark Olive Light Brown Medium Brown Dark Brown
Soft Black Black

How do you tan?: Burn Usually Burn Sometimes Burn Rarely Burn Never Burn
Never Burn/Black

Broken Capillaries: Do you have this condition? Y/N

If yes, where? Nose Cheek Area Chin Area Forehead Entire Face

If currently experiencing acne, or you have a history of acne or breakouts, which one(s) apply?:

Pimples Whiteheads Black heads Enlarged Pores Acne Scars Cysts Flakiness

Does your skin ever flake or feel tight and dry? Frequently Occasionally Rarely

Is your skin ever shiny a few hours after cleansing? Frequently Occasionally Rarely

How often do you experience breakouts? Frequently Occasionally Rarely

How noticeable are your pores? Very T-Zone Not Very

Do you have any problems healing from a cut or burn?: If yes, describe: _____

Have you ever had a cold sore or fever blister? Y/N

Do you work primarily inside? Y/N Occupation: _____

In the past have you neglected to use sunscreen? Y/N Do you currently use sun block? Y/N

Are you in the habit of going to tanning booths? Y/N Are you currently sunburn/windburn or red faced? Y/N

Current home skin care regimen: _____

Have you or anyone in your family had skin cancer?: Y/N

If yes, describe: _____

What conditions would you like to improve? (Circle all that apply)

Acne and/or Acne Breakouts Facial Scarring Enlarged Pores Uneven Skin Tone
Freckles/Age Spots Fine Lines Wrinkles Sagging Skin
Stretch Marks Weight Excess Hair Eyelash Scantiness
Body Contour Skin Tone Broken Capillaries Teeth Staining





What non-surgical cosmetic medical procedures would you like to learn more about?

(Circle all that apply):

- | | | | |
|-------------------|-----------------------|---|-----------------|
| Botox/Dysport | Microdermabrasion | Permanent Hair Reduction | Skin Tightening |
| Facials | Laser Teeth Whitening | Exfoliating Peels | Massage Therapy |
| Laser Liposuction | Stretch Marks | Skin Rejuvenation (Veins, pigmented lesions, etc) | |
| Body Contouring | Fraxel | Other: _____ | |

I confirm to the best of my knowledge, the answers I have given are correct and I have not withheld any information. I will inform my practitioner of any changes in my health or life style which may affect my treatments.

Client Signature: _____ Date: _____

Clinician Signature: _____ Date: _____
