Welcome To Our Medical Spa

(Please Print)

Name: ____
Last First Middle

Home Address: ____

City: ____________________________ State: ____________ Zip: _____________

Home phone: ( ) ____________________Work phone: ( ) __________________

Cell phone: ( ) ____________________ E-mail: ____________________________

At which number do you prefer to be contacted? ______________________________

Birth date: _________________ Sex: ___________Occupation: _____________

May send information to my home? Yes ____ No ____

Would you like to receive our e-newsletter with specials? Yes ____ No ____

How did you hear about us? ______________ ______________ __________________
(If radio or television, please specify station or channel)

Emergency Contact

Name: ______________________________ Relationship: _____________________

Home Phone: ( ) ___________Work: ( ) ___________ Cell: ( ) ___________

Signature: ____Date: _____________

Parental signature (if under the age of 18): __________________________________

Due the HIPAA (Health Insurance Portability and Accountability Act) all information must be completed on this form and the following forms. If you have any questions regarding this, anyone in our office will be glad to help you.

Thank you for choosing St. Louis Cosmetic Surgery Medical Spa!!

Medical Spa Profile and Assessment Tool

Name: ____ Today's Date: _______________

Date of Birth: ______________________________ Occupation: ______________________

We ask that all clients complete this profile prior to receiving any service. We use this information to accurately evaluate our client's specific needs. This information is completely confidential and used for analysis purposes only.

1. Do you have any health issues? Check all that apply:

☐ Headaches ☐ Back/Spinal Problems
☐ Gastrointestinal ☐ Fatigue
☐ Blood clots ☐ Varicose Veins
☐ Arthritis ☐ Pregnant or lactating
☐ Heart Problems ☐ Blood Pressure
☐ Bruise Easily ☐ Hormone Imbalance
☐ Skin Sensitivity ☐ Diabetes
☐ Difficult Breathing ☐ Epilepsy / Seizures
☐ Rosacea ☐ Claustrophobia
☐ Thyroid (overactive/underactive)
☐ Implants (i.e. pacemaker, pins in bones, etc.)
☐ Cancer _____________________
☐ Other Skin Problems ________________
☐ Allergies/Sensitivities _________________
☐ HIV Positive/Acquired Immune Deficiency Syndrome (AIDS)

2. Do you experience these conditions on your skin?

Flakiness Tightness Bruising
Oiliness Breakouts Redness

3. Are you using acne/aging products (oral/topical)?

Retin-A Renova Accutane
Differin Azelex Other _____

4. Have you ever had a reaction to any of the following?

Shellfish/Iodine Medicine Makeup
Sunscreens Fragrance/Dyes AHA's
Other________________________________

5. Have you been under a physician's care recently?
☐ Yes ☐ No For What?___________________

6. Have you had a massage before? ☐ Yes ☐ No

7. Have you had a facial treatment before? ☐ Yes ☐ No

8. Do you wear contact lenses? ☐ Yes ☐ No

9. Do you sun bathe or use tanning beds? ☐ Yes ☐ No

10. Are you using oral contraceptives? ☐ Yes ☐ No

11. Do you use a sunscreen? ____SPF# ☐ Yes ☐ No

12. Have you had microderms or chemical peels? ☐ Yes ☐ No

13. Do you smoke (including socially)? ☐ Yes ☐ No

14. Do you follow a specialized diet? ☐ Yes ☐ No

15. Do you exercise regularly? ☐ Yes ☐ No

16. How many 8oz glasses of water do you consume daily?________________________

17. How many **8oz** *caffeinated beverages* do you consume daily? ________________________

18. How many *alcoholic beverages* do you consume weekly? ______________________

19. List any medications and supplements you take regularly:
____

21. What skin care program are you currently using?
____

22. Have you started new medication, treatments or skin care products recently? If yes, specify:
____

23. What is your primary goal, improvements you desire?
____

24. Please list recent surgeries, hospitalizations, major illnesses, and accidents. (Please include dates)
____

I confirm that 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 lifestyle which may affect my treatments.

Client Signature: ____________________________________ *Date:* ________________________

Please circle any treatments or services you are interested in learning more about.

VISIA-Digital Complexion Analysis

Skin Care Products for Acne Control

Skin Care Products for Adult Complexions

Skin Care Products for Sun Damage/Wrinkles/Freckles/Pigmentation

Botox Treatments for Facial Frown Lines

Fillers/Collagen Replacement for Lines/Wrinkles

Chemical Peels for Facial Skin Improvement

Massage-Customized For Your Needs

Microdermabrasion Stimulates Skin Rejuvenation

IPL (Intense Pulse Light) Treats Redness, Rosacea, Age Spots & Sun Damage

Vein Treatment

Invisilift-Firms, Tones & Tightens Face

Thermage-Stimulates Collagen to Firm & Contour Face

Liposuction for Removal of Unwanted Fat Deposits

Eyelid Surgery

Facelift Surgery

Breast Augmentation Surgery

Nose Surgery

Ear Surgery

Abdominal Surgery