MSU Aesthetic & Laser Treatment Center Client Profile

Name_____Appointment date_____
Last First Middle Initial

Date of birth: _____/_____/_____ Sex: □ Male □Female

Address: _____
Street City State Zip

Phone: _____
Cell Work Home

Email: _____

How do you prefer to be reminded of appointments? □ Cell □ Email Reminder

Emergency Contact: _____
Name Relationship to Client Phone Number

How did you learn about our practice?

□ Physician □ Website □ Facebook Other_____

□ Hospital □ Seminar □ TV Ad Friend_____

□ Another Client □ RealSelf.com □ Radio □ Magazine

Cosmetic Interest Questionnaire: What are your concerns with your skin/appearance?

□ Forehead
□ Frown Lines
□ Bunny Lines
□ Crow's Feet
□ Facial Hair/Excessive Body Hair
□ Nasolabial Folds (nose to mouth lines)
□ Vertical Lip Lines (smokers lines)
□ Lip Volume
□ Marionette Lines (corners of mouth to jaw)
□ Thinning Eyelashes or Brows
□ Broken Capillaries
□ Redness or Rosacea
□ Under Eye Dark Circles
□ Freckles and Pigmentation (brown spots)
□ Loss of Skin Vibrancy
□ Larger Pores, poor skin texture and fine lines
□ Scarring
□Acne Lesions
□ Dry Skin
□ Oily Skin
□ Cheek Laxity
□ Jaw Laxity
□ Neck Laxity
□ Cellulite

Health History

	Yes	No		Yes	No
Pregnant/actively pursuing pregnancy/Breastfeeding			Seizure Disorder (Epilepsy)		
Develop cold sores/fever blisters			High Blood Pressure		
Have dry eyes			Myocardial Infarction/Pacemaker		
Have migraine headaches			Rosacea		
Have Myasthenia gravis/Lou Gehrig's Disease			Diabetes		
Have had a stroke or TIA(mini-stroke)			Fainting		
Heart Disease			Asthma		
Keloid			Hepatitis		
Smoke/use marijuana/recreational drugs			HIV/Aids		
Drink Alcohol_____per day_____per week			Cancer		
Auto-immune Disease					

Medications: Please list all medication you are presently taking (including oral and topical, prescription, vitamins, supplements, and non-prescription)
If none, please check □

Medication Name	Dosage	Frequency

All known allergies/sensitivities/adverse reactions (including those to pigments, dyes, and inks) _____
Hemophilia/Anticoagulants/Blood Thinners/Aspirin use_____
Are you currently using the following? If yes, please specify when.
□□Accutane □ Birth Control Pills □ Hormone Therapies □ Retinoic/Tretinoin Acid
Are you currently experiencing any menopausal symptoms? □ Yes □ No Please List: _____

How would you rate your current health? (Please circle) Not healthy 1 2 3 4 5 Very Healthy

Have you had a recent cosmetic surgery ☐ Yes ☐ No

Procedure	Date

Social History:

Occupation: _____ Employer: _____

Does your occupation or social activity place you at risk for any of the following? *Hepatitis B ☐Yes ☐No Aids ☐Yes ☐No*

Tuberculosis ☐Yes ☐No If yes, please explain: _____

Airline travel: ☐ Rare ☐ Occasional ☐ Frequent History of MRSA/VRE infection ☐ Yes ☐ No

Do you participate in vigorous activity or sports? ☐ Yes ☐ No If yes what kind? _____

Skin Care:

Are you currently or have you previously received the following skin care treatments?

☐ Facial Peel ☐Hydrafacial ☐ Dermaplaning ☐ Permanent make-up/tattooing/ microderm pigmentation

Are you currently or have you previously received lase resurfacing treatments? ☐ Yes ☐ No If so, when and what treatments_____

Do you get facial waxing, electrolysis, laser hair reduction or use depilatories? ☐ Yes ☐ No

Have you ever used products that cause a bad reaction? ☐ Yes ☐ No Please describe: _____

Are you currently using any skin-care products that contain active ingredients (Glycolic/Salicylic acid, Vitamin A) ☐ Yes ☐ No

How does your skin react to these products? _____

What is your current skin care routine? (Any recent use of Latisse or any other eyelash growth product).

Morning: _____

Evening: _____

Describe your skin:

☐ Normal	☐ Acne Prone	☐ Melasma/Hyperpigmentation	☐ Wrinkles	☐ Cystic Acne	☐ Rosacea
☐ Dry	☐ Cystic Acne	☐ Eczema	☐ Psoriasis	☐ Hypopigmentation	☐ Milia
☐ Oily	☐ Acne Scarring	☐ Sun Damaged	☐ Large Pores	☐ Broken Capillaries	☐ Sensitive
☐ Patchy Dryness	☐ Uneven/Blotchy	☐ Dry in Winter	☐ Resilient	☐ Not Sure	☐ T-Zone/Combination

Injectables and Fillers:

Have you ever been treated with Botox/Dysport/Xeomin ☐ Yes☐ No If so, when and what area(s)? _____

Have you ever been treated with filler? ☐ Yes ☐ No If so, when and what area(s)? _____

Have you taken aspirin or aspirin containing product within the last two weeks? (e.g. Motrin, Advil, Bayer) ☐ Yes ☐ No

Laser

Natural hair color: ☐ Blonde ☐ Light Brown ☐ Dark Brown ☐ Black ☐ Red Ethnic Background: _____

Skin Type: ☐ Type I (always burn, never tan) ☐ Type II (always burn, sometimes tan) ☐ Type III (sometime burn, always tan) ☐ Type IV (never burn, always tan)

Skin condition: ☐ Oily ☐ Normal ☐ Dry ☐ Rosacea ☐ Sun Damage ☐ Fine Lines ☐ Broken Capillaries ☐ Irregular Pigmentation

Have you been in the sun, used tanning beds or used sunless tanning products within the last two weeks: ☐ Yes ☐ No

Are you currently taking any medications that cause photo sensitivity (light or sun sensitivity)? ☐ Yes ☐ No

To the best of knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I have a change in health. I acknowledge and agree that I am financially responsible for all services rendered. I further acknowledge having access to a copy of the MSU Aesthetic and Laser Treatment Center Notice of Privacy Practices on the date below.

Patient's Signature: _____Date: _____