Belle Aimée Medical Spa-Laser and Cosmetic Center

CONFIDENTIAL MEDICAL HISTORY FORM

Name:____ Date:____

Address:____ Home Phone:______________________________________

City:____ Cell Phone:_______________________________________

St:____________ Zip:_____________ Work Phone:_______________________________________

Preferred phone to leave message: **H W C**

Date of Birth: ____________________ Age:__________ E-Mail:____

Please describe what you are hoping to achieve with this visit: ____

____

The following information is necessary for our clinicians to determine your eligibility for treatment.

List medications you are currently taking: (important to include birth control pills, aspirin, blood-thinners, laxatives, vitamins & herbs)

Medication & Dosage: ______________________________ Medication & Dosage: ______________________________

Medication & Dosage: ______________________________ Medication & Dosage: ______________________________

Are you taking any medications that indicate "Avoid sun exposure"? If so, which one?______________________________

Are you allergic to anything? (Latex, milk products, oils any scents (candles, oils)? Please describe:

____

Surgeries in the last year: ____

Y N Do you have poorly controlled endocrine disorders, such as **diabetes** or Poly Cystic Ovary? ____________________

Y N Are you currently trying to conceive?

Y N Are you pregnant or breast feeding?

Y N Do you have a condition stimulated by light? (lupus, porphyria, epilepsy)______________________________

Y N Do you have a pace maker or defibrillator?______________________________

Y N Do you have any metal implants? If yes, where:______________________________

Y N Do you have an impaired immune system? If yes, describe: ______________________________

Y N Do you have an active skin condition? (psoriasis, eczema, herpes, etc.) If yes, describe: ____________________

Y N Do you have a bleeding disorder? Are you on a blood thinner? If yes, describe: ______________________________

Y N Do you smoke? If you quit, how long ago was it? ______________________________

Y N Do you drink wine, beer or liquor? Amount per week: ______________________________

Y N Do you have a history of skin disorders, keloids, abnormal would healing as well as a very dry & fragile skin? If yes, explain on back

Y N Have you had a facial laser resurfacing or deep chemical peel in the past 3 months?

Y N Have you taken Accutane (severe acne) medication in the past 6 months?

Y N Have you waxed, tweezed or had electrolysis in the area to be treated in the last 6 weeks?

Y N Do you bleach any of your body hair or facial hair?

Y N Do you have Aids or HIV?

Y N Do you have Hepatitis? If yes, A, B or C (circle which one)

Y N Do you have excessively tanned skin from the sun, tanning beds or tanning creams within the last 2 weeks?

Y N Do you have any tattoos or permanent makeup in the treatment area?

Y N Do you have any severe concurrent conditions, such as cardiac disorders? Explain ______________________________

Y N Are you prone to getting cold sores or fever blisters?

If you have an disorder not mentioned or if you answered "yes" to any of these questions. Please explain on back--->

Skin Type:

How sensitive are you to the sun? Extremely______Very_______Moderately_______Minimally_______Not at all______

How easily do you burn in the sun? Always_______Sometimes_________Minimally_______Rarely_______Not at all_______

How well do you tan? Never______Minimally_______Gradually light to brown______Always to dark brown_______

Are you currently tanned? Yes_______No_______

How often do you tan? ______________________________

Please tell us if there is any more we should know about your health:______________________________

How did you hear about us?______________________________

I certify that the preceding medical, personal & skin history statements are true and correct. I am aware that it is my responsibility to inform the staff at Belle Aimée Med Spa of my current medical or health conditions and to update this history with any changes that may occur. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Signature:____Date______________________________