Le Beau Visage
Medical Spa

HEALTH INFORMATION FORM

Patient Name: _____ Date of Birth:_____ Today's Date:_____

Address: _____ City, State, Zip: _____

□ Home Phone: ( )_____ □ Work: ( )_____ □ Cell: ( )_____

E-mail:_____Occupation:_____Employer:_____

May we e-mail you for our monthly promotions and office information? Y / N

Are You Currently Under a Physicians Care? Y / N Please Specify:_____

How did you hear about us?_____ Referrer's Name (if applicable)_____

Emergency Contact:_____ Relationship To Patient: _____

Contact's Phone: ( )_____ Reason for Consultation?_____

Preferred Pharmacy Name: _____ Pharmacy Phone Number: ( )_____

Primary Care Provider Name: _____ Primary Care Provider Phone Number: ( )_____

Have you ever had any of the following conditions? Check all that apply.

____AIDS/HIV
____Anemia
____Arthritis
____Artificial Joint
____Artificial Heart Valve
____Asthma/COPD/Bronchitis
____Auto Immune Deficiency
____Blood Disease
____Bleeding Disorders
____Chemotherapy (active)
____Crohn's Disease
____Clotting Disorders
____Contacts
____Deep Vein Thrombosis (DVT)
____Diabetes
____Diseases of arteries/vessels
____Dizziness
____Eating Disorders
____Epilepsy
____Eye Surgery
____Eye Problems
____Fainting
____Gallstones/Gallbladder Disease
____Glaucoma
____Hay Fever
____Heart Murmur
____Heart Disease
____Hepatitis
____Herpes
____High Blood Pressure
____Hypertension
____Infective Endocarditis
____Irritable Bowel Syndrome (IBS)
____Keloid Scarring
____Kidney Disease (Including CKD)
____Liver Disease
____Lupus
____Medullary Thyroid Cancer (MTC)
____Melanoma
____Mental Health Problems
____Nervous Disorder
____Neurological Problems (Including Parkinsons
____Pacemaker/Defibrillator
____Pancreas/Digestion Problems
____Parathyroid/Adrenal Glands
____Phlebitis
____Pulmonary Embolism (PE)
____Radiation Treatment
____Respiratory Problems
____Skin Conditions
____Smoke
____Sinus Problems
____Stomach/Duodenum Problems
____Stroke
____Substance Abuse
____Thyroid Disease/Problems
____Tuberculosis
____Ulcers/Ulcerative Colitis
____Venereal Disease
____Other _____
____None/ Not Applicable

ALLERGIES – Please List | **Have you ever had:** (Circle)

Medication **Allergies**: _____
Cosmetic **Allergies**: _____
Latex/Other **Allergies**: _____

Cold Sore:	YES		NO
Fever Blister:	YES		NO
Frequency:	<1/year	1-3/year	4+/year

Have you ever/are you currently using: (Circle)

Retin-A, Renova or any retinoic product:	YES-Currently	YES-In the Past	NO
Accutane:	YES-Currently	YES-In the Past	NO
Prescription Acne Medication:	YES-Currently	YES-In the Past	NO
Steroids:	YES-Currently	YES-In the Past	NO

WOMEN ONLY – Please complete

Are you pregnant or planning to become pregnant? _____ If yes – What is your due date? _____

Could you be pregnant? _____ Are you breastfeeding? _____

Are you on any type of hormone replacement therapy? _____

Are you on any contraceptive methods? If yes, what? _____

Have any of your family members ever had any of the following conditions?
(Write relation to family member beside corresponding condition)

_____Abnormal Bleeding
_____Abnormal Clotting
_____Adopted
_____Anesthesia Problems
_____Autoimmune Disorders
_____Brain Tumor
_____Breast Cancer
_____Cleft Lip/Cleft Palate
_____Diabetes
_____Drug Allergies
_____Endocrine Disease
_____Hearing Loss
_____Heart Disease
_____Hemophilia
_____High Blood Pressure
_____Kidney Disease
_____Liver Disease
_____Lung Cancer
_____Malignant Hyperthermia
_____Other Cancer
_____Ovarian Cancer
_____Prostate Cancer
_____Skin Cancer
_____Skin Disease
_____Substance Abuse
_____Thyroid Problems
_____Von Willebrand
_____ Other _____

Please list all medications/supplements that you are currently taking
(Including topical medications, self-prescribed medications, dietary supplements, vitamins, etc.)

_____ _____ _____ _____

_____ _____ _____ _____

Previous Cosmetic Treatments (Circle)

Acid Peel: YES NO Date: _____
Microdermabrasion: YES NO Date: _____
Botox / Dysport: YES NO Date: _____
Collagen / Restylane: YES NO Date: _____
Tattoo: YES NO Date: _____
Permanent Makeup: YES NO Date: _____
Waxing: YES NO Date: _____
Facial Surgery: YES NO Date: _____
Laser Surgery: YES NO Date: _____
Skin Resurfacing: YES NO Date: _____
PhotoFacial (IPL): YES NO Date: _____
Laser Hair Removal: YES NO Date: _____
Sclerotherapy: YES NO Date: _____
Other: _____ Date: _____

What are your concerns about your skin?

*Acne
*Acne Scarring
*Anti-aging/Prevention
*Birthmark
*Blackheads
*Brown Spots/Melasma
*Cellulite
*Deep lines
*Fine Lines
*Hair Reduction
*Hyperpigmentation
*Hypopigmentation
*Large Pores
*Lip Volume
*Loose/Sagging Skin
*Makeup
*Redness
*Rosacea
*Scarring
*Skin Texture
*Sun Damage
*Tear Trough (Dark Circles)
*Visible Veins
*Weight Loss

Please list all past surgeries/hospitalizations, medical or diagnostical tests and any complications you have had

_____ _____ _____ _____

_____ _____ _____ _____

When did you last tan your skin? _____ Sun, tanning beds, creams? _____

When a scar appears on your skin, is it significantly dark in color? _____

In your own words, describe your skin. _____

What are you hoping to improve with your skin? _____

Please list your current skin care regimen:

AM:
Cleanser _____
Treatment _____
Moisturizer _____
Eye Cream _____
SPF _____
Make Up _____
Other _____

PM:
Cleanser _____
Treatment _____
Moisturizer _____
Eye Cream _____
Retin A/Retinol_____
Other _____

Please complete the following questions if you are interested in Semaglutide GLP-1 Weight Loss Program

Are you currently taking any blood thinners? _____

Weekly alcohol intake? _____

Do you or have you ever smoked/vaped/used tobacco? _____

***In an effort to keep our patients informed, we periodically send monthly email correspondence. By signing below, I acknowledge and consent to receiving these emails. I may, however, opt-out at any time provided written notice is given.**

*** We request that all office visits are paid in full at time of service, any payment arrangements must be made prior to appointment. Acceptable forms of payment are Cash, Care Credit, Visa, American Express, Discover and MasterCard. We apologize, but we do not accept Checks.**

Patient Signature: _____ Date:_____