de la Belle
WELLNESS & SPA
Aesthetics Weight Loss Laser

CLIENT INFORMATION & MEDICAL HISTORY

In order to provide you with the most appropriate treatment, we need you to complete the following questionnaire. All information is strictly confidential.

PERSONAL HISTORY

Client Name _____ Today's Date_____

Date of Birth_____Age_____Occupation_____

Home Address_____City_____ State___
Zip Code_____Home Phone (__)_____ Cell Phone (___)_____
Email_____
Emergency Contact Name/Phone:_____

How were you referred to us? _____

How did you hear about us? (Please circle all that apply) Google Yelp 4Memphis Magazine
TalkWith Me (phone app) Social media (ex.facebook,Instagram) OTHER:_____

MEDICAL HISTORY

Are you currently under the care of a physician? Yes □ No □

If yes, for what:_____

_____

Do you have any of the following medical conditions? (Please check all that apply)

Cancer □ Diabetes □ High blood pressure □ Post stroke□ Arthritis □ Frequent cold sores □ HIV/AIDS □
Keloid scarring □ Skin disease/Skin lesions □ High Chol □ Chronic HA □ ADHD □

Seizure disorder □ Hepatitis □ Hormone imbalance □ Thyroid imbalance □ Blood Clotting

Abnormalities □ Recent Surgery □ Eye Disorders □ Depression□ Anxiety □ Herpes Simplex □

Autoimmune □ Any active infection □ Smoke □

Do you have any other health problems or medical conditions? Please list: _____

_____

Have you ever had an allergic reaction? (List any and all that you have had and describe the reaction you experienced)
Food _____ Animal Protein _____ Aspirin_____ Lidocaine _____ Hydrocortisone _____ Hydroquinone or skin bleaching agents____ Shell Fish_____
Iron_____Eggs_____Cosmetics_____Fabrics_____Chemicals_____Latex____Others_____

MEDICATIONS

What oral prescription medications are you presently taking? Birth Control pills_____

Hormones _____ Others (It is required that you list all of them)

_____

_____

What antibiotics do you use to treat infections?_____

_____

Do you take any medications for heart conditions? _____

Are you on any mood altering or anti-depression medication? _____

What topical medications or creams are you currently using? RetinA , Renova, Others (Please list):

_____

What herbal supplements do you use regularly?_____

Are You Currently Taking Aspirin, Aspirin containing products, or any other blood thinning medications such as; Coumadin, Plavix, Heparin, herbal blood thinning products? Please list or

N/A_____

HISTORY

For our female clients:

Are you pregnant or trying to become pregnant? Yes No Are you breastfeeding? Yes No

Are you using contraception? Yes No Have you recently changed your birth control? Yes No

SKIN CARE

1) Have you ever had a facial treatment before? YES NO If yes, when? _____

2) Have you ever had a body spa treatment before? YES NO If yes,what was your treatment and when?_____

3) Have you ever had a Massage? YES NO

4) What type of massage pressure do you prefer? SOFT SWEDISH HARD or I PREFER NOT TO HAVE A MASSAGE

5) Which of the following best describes your skin type? (Circle all that apply)

Always burns easily, never tans	Oily skin	Wrinkled, Fine Lines
Always burns, tans slightly	Dry Skin	Fair/Light skin tone
Burns moderately, tans gradually	Combination	Medium skin tone
Seldom burns, always tans well	Sun damage	Dark skin tone
Rarely burns, deep tan	Redness	Itchy Skin
Never burns, deeply pigmented	Acne-Are you currently having breakouts? YES NO	

6) Have you recently used any self-tanning lotions/ creams or had a spray tan? YES NO

7) Do you have any special skin problems or concerns pertaining to your face or body?

Yes No Specify:_____

8) Have you ever had chemical peels, laser or microdermabrasion? YES NO If yes, when?_____ What for?_____

9)Do you use Retin-A, Renova, Adapalene Hydroxyl Acid or Retinol/vitamin A derivative products? YES NO Describe:_____In the last 3 mths? YES NO

10) What skin care products are you currently using? (List brand where known)_____ Do you use products that contain AHA'S or BHA's such as Glycolic or Salicylic Acid? YES NO If yes, please describe_____

11) Have you used any of the following hair removal methods in the past six weeks? (circle all that apply).

Shaving Waxing Electrolysis Plucking Tweezing Stringing Depilatories NO

12) Have you ever had an allergic reaction to any skin care product that you know of? (Please explain)_____

13) What SPF do you use on your face? _____ How often/when? _____

14) Have you experienced Botox or Filler Injectables? YES NO If yes, please specify_____

15) Do you regularly sun bathe or use tanning salons?_____How often? _____

16)Are you sensitive to fragrances? (ex.lavender,peppermint) YES NO If yes, please describe_____

I certify that the preceding medical, medication and personal history statements are true and correct. I am aware that it is my responsibility to inform the doctor or other health professional of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Signature_____ Date:_____

FNP or Physician Signature_____