La Bella Vida
SPECIALTY AESTHETICS

PATIENT MEDICAL HISTORY

Name: _____ Today's Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____ Date of Birth: _____

Cell Phone:_____ Home Phone:_____ Work Phone:_____

Best number to reach you? □ Cell Phone □ Home Phone □ Work Phone

How did you hear about us? _____Referral Name: _____

What is the nature of your visit? _____

What are your expectations? _____

PERSONAL MEDICAL HISTORY:

Please check all the Medical Conditions that apply.

Acne	□	NONE	□
Arthritis	□	Hepatitis B or C	□
Asthma	□	HIV/AIDS	□
Bell's Palsy	□	Keloids	□
Bleeding Disorder	□	Permanent Makeup	□
Blood Clotting Disorder	□	Rosacea	□
Cancer	□	Seizure Disorder	□
Cold Sores/Herpes Simplex	□	Skin Cancer	□
Diabetes	□	Skin Lesions	□
Heart Condition	□	Tattoos	□
High Blood Pressure	□	Thyroid Disorder	□
Connective Tissue Disorder	□	Defibrillator/Pacemaker	□
Allergy to Latex	□	Allergy to Lidocaine	□
		Other _____	

Are you Pregnant? □ Yes □ No □ N/A
Are you Nursing? □ Yes □ No □ N/A
Do you exercise? □ Yes □ No
Do you Smoke? □ Yes □ No

La Bella Vida
SPECIALTY AESTHETICS

Please list all medication you are currently taking: (Please include vitamins, herbal supplements, topical creams, etc.)

_____

List any allergies to medication: □ N/A _____

List all medical conditions for which you are currently under the care of a physician: □ N/A

_____

Are you currently using:
□ Aspirin □ NSAIDS (Motrin, Advil, Aleve) □ Blood Thinners

SKIN HISTORY:

Have you had:
Previous reaction / hypersensitivity to Laser Treatments? □ Yes □ No
Have you been on Accutane in the past 6 months? □ Yes □ No

Acne:
Do you have a history of breakouts? □ Yes □ No
If so, what is the frequency of your breakouts? ___ Frequent ___ Occasional ___ Rarely
Do you experience cystic breakouts? □ Yes □ No
Do you have any scarring as a result of your acne? □ Yes □ No

Skin Background:
Have you had prolonged sun exposure (or tanning bed) in past 3 days? □ Yes □ No
If so, are you currently sunburned? □ Yes □ No
Do you use tanning beds? □ Yes □ No
Are you using chemical tanning solutions? □ Yes □ No
Do you use sunscreen on a regular basis? □ Yes □ No

Fitzpatrick I-VI:
Check one (when exposed to the sun without protection for approximately 1 hour):
□ (I) Always burns, never tans
□ (II) Usually burns, tans less than average
□ (III) Sometimes mild burn, tans about average
□ (IV) Rarely burns, tans more than average
□ (V) Rarely burns, tans profusely
□ (VI) Never burns, deeply pigmented

Skin Type: Are you tan? □ Yes □ No
□ Caucasian □ Mediterranean
□ Asian □ African American
□ Hispanic □ Other: _____

Have you waxed, used depilatories, bleaches or other chemical processes? □ Yes □ No

How much water do you normally consume daily?_____

Have you had:
Microdermabrasion □ Yes □ No Chemical Peel □ Yes □ No Laser Resurfacing □ Yes □ No

Do you have:
Rosacea □ Yes □ No Wrinkle Concerns □ Yes □ No
Scarring Concerns □ Yes □ No Sun Damage Concerns □ Yes □ No
Pigmentation Concerns □ Yes □ No Broken Capillary Concerns? □ Yes □ No
Have you had Botox or other cosmetic injections in the past 6 months? □ Yes □ No
If yes and less then 3 months, approximate date? _____

Do you use topical ointments?
□ Retin-A □ Glycolic Acid □ Lactic Acid □ Hydroquinone
Other: _____

What type of skin care products are you using? _____

Please check services of interest:
□ Laser Hair Removal (list areas) _____
□ Vein Removal □ Fat Reduction Treatment
□ Laser Genesis, Laser Facials, Acne Treatment
□ Pigmented Lesions or Brown Spot Removal
□ Microdermabrasion/Chemical Peels
□ Duo- Sexual dysfunction for male/female
□ Skin Tightening Treatment
□ Botox, Dysport, Xeomin
□ Dermal Fillers
□ Injectables- PRP

Other: _____

La Bella Vida Policies

Cancellation Policy

Your appointment time is exclusively reserved for you. Please give 24 hours' notice before your appointment if you need to cancel. Failure to give requested notice more than two (2) times may lead to La Bella Vida requiring a $50 credit card deposit to schedule your next appointment.

Patients arriving more than 10 minutes late for an appointment may result in a shortened appointment or may necessitate rescheduling if there is not enough time to complete services safely.

La Bella Vida
SPECIALTY AESTHETICS

Returns/Exchanges

If you are not satisfied with a retail purchase made at La Bella Vida, we will gladly offer you a credit which can be used toward future retail purchases, only if a package is purchased. All returns or exchanges must be made within 30 days of purchase.

Payment

We gladly accept Visa, Master Card, American Express, Discover, Care Credit, personal checks and cash. Payment is expected at the time of service.

Electronic Devices

For the comfort of all, please mute cellular phones and laptops. To ensure patient privacy, please refrain from taking any pictures within La Bella Vida.

---------- O ----------

I certify the above medical history information is accurate and correct. I am aware it is my responsibility to inform the Provider of any changes to my medical history. A current medical history is essential to execute appropriate treatment.

I understand La Bella Vida's policies as outlined and agree to the terms:

Patient Signature: _____ Date: _____

* Periodically, we send mailings, e-mails or text messages to notify our valued patients of promotions, discounts, and special events. Please let us know if you wish to receive our emails:
□ Yes □ No

The above patient medical history has been reviewed.

Provider Signature: _____ Date: _____

La Bella Vida
SPECIALTY AESTHETICS

PHOTO CONSENT AND RELEASE FORM

Patient Name: _____

I consent for photographs and/or video images to be taken of me by La Bella Vida or a representative. I understand the images will be a part of my medical record and may be used for purposes of medical teaching or training or for marketing purposes (website, print, digital or social media).

By consenting to photographs and/or video images I understand I will not be compensated from any party. Although photographs and/or video images will be used without identifying information such as name, I understand it is possible someone may recognize me.

I further acknowledge that my participation is voluntary and agree that use of any photographs and/or video images confers no rights of ownership or royalties whatsoever.

I authorize the use of photographs and/or video images: (please initial indicating YES or NO below)

_____ YES _____ NO For educational purposes (medical teaching or training),

_____ YES _____ NO For marketing and advertising purposes (website, print, digital, or social media),

_____ YES _____ NO At my request, my photographs and/or video images will only be used as part of my medical record.

I hereby release La Bella Vida, LLC, its employees, and any third parties involved in the creation of or publication of educational or marketing materials, from liability for any claims by me or any third party in connection with my participation.

By signing this form, I confirm understanding of this consent. If I wish to withdraw my consent in the future, I may do so via written request submitted to La Bella Vida or by completion of a new form.

Patient Signature: _____ Date: _____