Print Form

YOUTHFUL YOU PATIENT INFORMATION AND HEALTH HISTORY

Date:	**Name:**			
Address:		**City:**	**State:**	**Zip:**
Age:	**Birth date:**	**Gender:** ☐ M ☐ F	**Race/Ethnic Background(s):**	
Phone number where you can be contacted:			**Can we leave you a message?** ☐ Yes ☐ No	
Home:			☐ Yes ☐ No	
Cell:			☐ Yes ☐ No	
Office:			☐ Yes ☐ No	
Email Address:			***(Please list if you want information on specials.)***	
Emergency Contact:	**Relationship:**		**Phone:**	
How did you hear about us?				
Reason for your visit today?				

PERSONAL HEALTH HISTORY

ALLERGIES
Medication: ☐ Yes ☐ No **If yes, list:**

Latex: ☐ Yes ☐ No **Sulfites:** ☐ Yes ☐ No **Nickel:** ☐ Yes ☐ No **List Other Allergies:**

Medical History

Disease	Yes	No	Describe	Disease	Yes	No	Describe
Heart	☐	☐		Cancer/Radiation/Chemo	☐	☐	
Lung/Tuberculosis	☐	☐		Polycystic Ovaries	☐	☐	
Circulation (blood clot, varicose veins)	☐	☐		Have you ever had a cold sore/fever blister?	☐	☐	Frequency/Year
Kidney	☐	☐		Neurologic disorder	☐	☐	
Liver/Hepatitis	☐	☐		Bleeding disorder	☐	☐	
Diabetes Mellitus	☐	☐		HIV Positive	☐	☐	
Seizures	☐	☐		Hepatitis C	☐	☐	
Depression/Anxiety/Other	☐	☐		Other	☐	☐	

Dermatological History
Have you ever been treated for any skin problems? ☐ Yes ☐ No **Explain:**

Disease	Yes	No	Describe	Disease	Yes	No	Describe
Skin Type	☐	☐	☐Oily ☐Dry ☐Combo ☐Normal	Eczema/Psoriasis	☐	☐	
Acne	☐	☐		Rosacea	☐	☐	
Accutane use	☐	☐		Excess or dark hair	☐	☐	
Moles	☐	☐		Keloid scarring	☐	☐	
Skin Cancer	☐	☐		Melasma/Dark Pigment	☐	☐	
Sun/age spots	☐	☐		Other	☐	☐	

Cosmetic Skin Care/Treatment History
Have you ever had any of the following?

Procedure	Yes	No	Date	Describe	Procedure	Yes	No	Date	Describe
Facial/Peel	☐	☐			Microdermabrasion	☐	☐		
Botox	☐	☐			Intense Pulsed Light	☐	☐		
Dermal Filler	☐	☐			Excess or dark hair	☐	☐		
Hair Removal	☐	☐			Permanent Makeup	☐	☐		
Wax/depilatories	☐	☐			Facial implants	☐	☐		
Sclerotherapy	☐	☐			Other	☐	☐		

Surgeries:

Medication History: (including over the counter, aspirin, ibuprofen, vitamins, herbals, birth control and topical)

Name of medication	Reason for taking	Name of medication	Reason for taking

WOMEN ONLY

		Describe			Describe
Currently pregnant	☐ Yes ☐ No		Postmenopausal	☐ Yes ☐ No	
Currently lactating	☐ Yes ☐ No		Actively conceiving	☐ Yes ☐ No	
Regular periods	☐ Yes ☐ No		Other	☐ Yes ☐ No	

Occupation: Employer:

Alcohol: ☐ Yes ☐ No Amount day/week Smoking: ☐ Yes ☐ No Amount /ppd How long?

Have you ever used any of the following for skin conditions/cosmetic reasons?

		Describe	Last Used
Retin A/Retinol	☐ Yes ☐ No		
Accutane	☐ Yes ☐ No		
Hydroquinone (bleaching cream)	☐ Yes ☐ No		
Do you use sunscreen?	☐ Yes ☐ No	SPF/Frequency:	
Other:	☐ Yes ☐ No		

How does your skin respond to the sun without the use of sunscreen?

Always burn ☐ Sometimes burn ☐ Burns then turns ☐ Tans very easily ☐ Other

What brand and types of skin care products do you currently use (i.e., cleanser, toner, exfoliator, moisturizer)?
AM
PM

Initial each of the following:

(initials) Failure to provide 24 hour notice for cancellations, changes or missed appointments will result in a 50% charge of the full treatment fee. If you have a prepaid package you will forfeit one of your treatments.

(initials) Skin care compliance: I understand that if I choose not to use skin care products/medications as recommended or comply with treatment recommendations, I may not achieve the benefits of treatment and/or desired outcome. I also agree to inform you of any questions or problems that I have regarding any treatment, procedure and/or home care products.

I certify that the information I have provided is accurate to the best of my knowledge. I also agree to inform Belle Vie MedSpa of any changes in any of the above information prior to any treatment, procedure, and/or use of any skin care products/medications.

Patient Signature: **Date:**

Parent/Guardian signature if patient < 18 years old: **Date:**

Belle Vie MedSpa Use: I have read the patient information and history (signature/title/date):

Signature: ☐ RN ☐ ARNP ☐ Cosmetologist ☐ Other: Date: