la chelé
MEDICAL AESTHETICS

PRINT CLEARLY PLEASE

Last Name: ___________________________ **First Name**: _________________________
Address: _____________________________**City:** ____________________**State:**_____**Zip:** _________
Telephone: (Cell/Home) _____________________ **Email:** _____________________________
Do you approve for us to leave you a message? **YES** or **NO**
Do you approve of text communication for appointment confirmations/follow-ups? (No marketing)
YES or **NO**
Date of Birth: _________________ **Age:** ___________
How did you hear about La Chelé Medical Aesthetics? *Please **check or input** which source applies to you*

- Facebook
- Instagram
- TikTok
- Referred By:_____________________
  (**One patient only please. First and Last name**)
- Physician: __________________________

Emergency Contact:____________________________**Phone:**________________________________
What treatment are you interested in? :____

Your Weight: _________
Your Height: _________

Please answer all of the following questions YES or NO

1. Do you have any current or chronic medical illnesses?
   YES or **NO**
   Please List: ____
2. Do you have any skin conditions or skin concerns?
   YES or **NO**
   Please List: ____
3. Do you take any medications (prescriptions, herbal/natural, or topical) on a daily basis?
   YES or **NO**
   Please List: ____
4. Do you or have you ever had any allergies or skin reactions to medicines, lidocaine, food, latex, products or other substances?
   YES or **NO**
   Please List: ____
5. Do you get cold sores of mouth or history of keloid scarring?
   YES or **NO**
6. Have you taken Accutane, Aspirin, Plavix or Coumadin in the last 6 months?
   YES or **NO**
   If yes, please list: ____
7. Do you smoke?
   YES or **NO**
8. Do you consume more than 2 glasses of alcohol per day?
   YES or **NO**

9. Have you ever had Botox?
   YES or **NO**
   If yes, when? Please list: ____
10. Have you ever had Dermal fillers?
   YES or **NO**
   If yes, when? Please list: ____
11. Have you ever had a laser procedure?
   YES or **NO**
   If yes, when? Please List: ____
12. Have you had any cosmetic surgeries?
   YES or **NO**
   If yes, when? Please List: ____
13. Do you regularly use/wear sun protection?
   YES or **NO**
14. What daily skin care products do you use?
   Please List: ____

FEMALES ONLY

15. Are you or could you be pregnant?
   YES or **NO**

16. Are you currently breast feeding?
   YES or **NO**

17. Do you give us permission to speak to anyone, other than yourself, regarding your care?
   YES or **NO**
   If yes, please provide contact name and number: ______________________________

Signature: ____________________________________ Date: __________________

WE ARE HIPAA COMPLIANT

The HIPAA Privacy Rule provides federal protection for individually identifiable health information held by covered entitles and their business associated and gives patients an array of rights with respect to that information. At the same time, the Privacy Rule is balanced so that it permits the disclosure of health information needed for patient care and other important purposes. Please ask if you would like to see a full copy of privacy practices.

OFFICE USE ONLY

MH Entered
Date: ____________________ *Employee Name:* ____________________
Email Registered
Date: ____________________ *Employee Name:* ____________________
Ambassador Entered
Date: ____________________ *Employee Name:* ____________________
Scanned and uploaded
Date: ____________________ *Employee Name:* ____________________