

LE CELLE

HEALTH SUMMARY

Medical Wellness and Aesthetics

Last Name: _____ First Name: _____ Date of Birth: _____

Address: _____ Unit#: _____ City: _____ State: _____ Zip: _____

Best Phone # to call: _____ Okay to leave a message? Y/N Alternate #: _____

Email : _____ Referred by: _____

What is the reason for today's visit?

ALLERGIES **NONE** _____

(Include Latex, food or cosmetic sensitivities)

MEDICATIONS / SUPPLEMENTS **NONE**

(include medication doses, date started, also include birth control pills, herbs, vitamins, dietary supplements, and over-the counter)

PRESENT HEALTH CONDITIONS **NONE**

MEDICAL HISTORY (CHECK IF "YES")

<p>Allergy and Ears, Nose and Throat: Problems with: <input type="checkbox"/> Sinuses <input type="checkbox"/> Vision <input type="checkbox"/> Hearing</p> <p>Cardiovascular: <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Irregular Heart Beat or Murmur <input type="checkbox"/> Heart Disease <input type="checkbox"/> High Cholesterol</p> <p>Dermatology: <input type="checkbox"/> Acne <input type="checkbox"/> Keloid Scarring <input type="checkbox"/> Skin Ulcers <input type="checkbox"/> Skin Cancer <input type="checkbox"/> Skin Disease, Type: _____</p> <p>Endocrine: <input type="checkbox"/> Diabetes/High Blood Sugar <input type="checkbox"/> Thyroid Problems – too high or too low (circle one) <input type="checkbox"/> Other Hormonal Problems</p> <p>Gastrointestinal: <input type="checkbox"/> GERD <input type="checkbox"/> Ulcers <input type="checkbox"/> Bleeding from Bowels <input type="checkbox"/> Irritable Bowel <input type="checkbox"/> Liver Disease</p> <p>Genitourinary and Gynecology: <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Prostate Problems <input type="checkbox"/> Ovarian or Uterine Problems</p> <p>Hematology and Oncology: <input type="checkbox"/> Anemia <input type="checkbox"/> Blood Clot <input type="checkbox"/> Bleeding Problems <input type="checkbox"/> Blood Transfusion <input type="checkbox"/> Cancer, Type: _____</p> <p>Musculoskeletal and Rheumatologic: <input type="checkbox"/> Gout <input type="checkbox"/> Arthritis, Location: _____ <input type="checkbox"/> Injury, Location: _____</p> <p>Immunity: <input type="checkbox"/> Immunodeficiency <input type="checkbox"/> Herpes (Cold Sores)</p> <p>Neurologic: <input type="checkbox"/> Seizures <input type="checkbox"/> Stroke <input type="checkbox"/> Syncope or Pre-syncope (passing out) <input type="checkbox"/> Neuropathy <input type="checkbox"/> Headaches, Type: _____</p> <p>Respiratory: <input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema/Chronic Bronchitis/COPD <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Sleep Apnea</p> <p>Psychiatric: <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Bipolar <input type="checkbox"/> Sleeping Problems <input type="checkbox"/> History of Abuse (Physical, Substance, Emotional)</p>
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SURGERIES and PROCEDURES (Include biopsies and dates)**NONE**

GENERAL HABITS**Date of Last Physical Examination?** _____ **Date of last lab studies?** _____**Exercise:** Never Rarely Yes, Frequency, Type: _____**Daily Water Intake:** _____ glasses per day**Sleep:** Hours each night _____**Alcohol:** Yes No How much? _____ How often? _____**Smoking:** Have you ever smoked: Yes No How many years? _____ How much? _____ If quit, when? _____Do you use smokeless tobacco: Yes No Do you have second hand smoke exposure? Yes No**Drugs:** Yes No Type: _____ Past Use? Yes No**Please rate your current level of stress:** High Moderate Low **Sources of stress:** Work Family Other _____**Occupation:** _____**SKINCARE** (Complete if you are interested in any of Le Celle Aesthetic services)

NO YES

 Are you pregnant or trying to become pregnant? Do you spend a lot of time outdoors or use a tanning bed often? Do you have any tattoos or permanent makeup? Area of Body _____**Which skin problems concern you the most (Check all that apply):** Sun Damage Brown spots (Hyperpigmentation) White spots (Hypopigmentation) Uneven skin tone Visible exposed blood vessels Hard bumps under skin Enlarged pores Clogged pores Blackheads /Whiteheads Acne Excessive oiliness Pimples Upper lip lines Wrinkles Scarring Sun Spots Dry patches Unwanted Hair Other: _____**What do you consider your skin type:** Dry Combination Oily Normal**When in the Sun do you** Always burn Sometimes burn Rarely burn Never burn

SKINCARE CONTINUED

Please check all home care products you currently use and list the BRAND NAMES:

- Cleanser _____ Sunscreen _____
- Moisturizer _____ Retin- A Cream _____
- Night Cream _____ Hydroquinone _____
- Eye cream _____ Vitamin C _____
- Toner/ Astringent _____ Other _____

Have you undergone any of the following treatments: (check all that apply)

- Dermal Fillers (Collagen/Restylane/Radiesse/Juvederm/Other) Area _____ When _____
- Botox Area _____ When _____
- Sculptra When _____
- Cosmetic Surgery Area _____ When _____
- Laser Treatment Laser Type _____
Area _____ Type of Treatment _____ When _____
- Accutane Completed? Y / N When _____
- Microdermabrasion
- Chemical Peel
- Other _____

Are you currently removing hair by any of the following methods?

- Waxing Tweezing "Nair" type products Electrolysis

If so when was it last done _____ what area _____

The above information is current and correct to the best of my knowledge.

Patient/Guardian Signature

Date

I have reviewed the above history.

Le Celle Name and Signature

Date

**In Accordance with the Federal Government and Health Portability and
Accountability Act
Patient Consent to the Use and Disclosure of Health Information
for Treatment or Healthcare Operations
(HIPAA)**

Le Celle would like you to take a moment to read this disclosure thoroughly. Please remember this disclosure does not give us permission to send your protected health information to anyone unless they are part of your medical treatment. We regret to inform you that if you choose not to sign this yearly disclosure we will not be able to disclose any information that is pertinent to your medical treatment.

I understand that as part of my health care Le Celle originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Le Celle is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Le Celle reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Le Celle change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept / decline (circle one) the terms of this consent.

Patient's Signature _____

Date _____

