



*Welcome to:*

## *Labelle MD Esthetics*

We are honored to be your care provided and look forward to serving you!

Please note:

If you are unable to make your appointment, kindly notify us as soon as possible.

Cancellations made less than **24 hours** before your appointment will result in a **\$150.00 cancellation fee** to ensure our team's time and resources are respected.

Thank you for your understanding and cooperation!

Signature: \_\_\_\_\_

Name: \_\_\_\_\_

Date: \_\_\_\_\_



**Personal information:**

First Name: \_\_\_\_\_ Last name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email Address \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Race / Ethnicity: \_\_\_\_\_

**Emergency Contact:**

First Name: \_\_\_\_\_ Last name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

**How did you hear about our clinic?**

Friend    Google search    Facebook    Instagram  

Other \_\_\_\_\_

If referred by someone, please provide their name for incentives:

\_\_\_\_\_



**Health Information:**

Do you have important pertinent medical problems?

Yes (Please list below)     No

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Current Medications / supplements (list below):

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Do you currently smoke?     Yes, Amount: \_\_\_\_\_     No

Do you drink alcohol?     Yes, Amount: \_\_\_\_\_     No

Any allergies (Medications, Foods, Latex, supplements, etc.) \_\_\_\_\_

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Describe Allergic Reaction: \_\_\_\_\_

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Do you take or use the following?

Accutane     Hydrocortisone \_\_\_\_\_% (Steroid Creams)

Retinol based creams/products     Oral Antibiotics \_\_\_\_\_%

What skincare products are you currently using? \_\_\_\_\_

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Do you wear sunscreen daily?  Yes     No

Do you use Tanning bed?  Yes, how often? \_\_\_\_\_  No

When was the last time you used a tanning bed? \_\_\_\_\_

Have you ever had skin cancer?

Yes, when and what kind? \_\_\_\_\_  No

History of Melasma?  Yes     No



Do you have autoimmune disease?

Yes, what kind? \_\_\_\_\_  No

Any bleeding prolonging medications/supplements you are currently taking daily? Please check below:

Aspirin  Fish oil  Advil  Naproxen  Aleve  Xarelto  Eliquis  Coumadin  Others

Have you had a cold sore?  Yes, when was your last outbreak? \_\_\_\_\_  No

Do you have problems with bleeding?  Yes  No

**Women Only:**(others please continue to “Sensitivity and Pigmentation” section)

Are you pregnant or trying to become pregnant?  Yes  No

If you have been pregnant, did you have hyperpigmentation or a “pregnancy mask” during pregnancy?

Yes  No

Are you currently breast feeding?  Yes  No

If you are still menstruating, do you have regular periods?  Yes  No

**Sensitivity and Pigmentation:**

Do you have acne breakouts?  Yes  No

How often do you experience a breakout? (select below)

Always  Occasionally (monthly)  Rarely  Near/During Menstrual cycle

What kind of breakouts do you have/had? (select below)

Pimple  Pustules  Cysts  Acne Scars  Other \_\_\_\_\_

Select below, when you go out into the sun, do you:

Always Burn  Usually Burn  Sometimes Burn  Rarely Burn  Almost Never Burn  Never burn

Do you have uneven pigmentation?  Yes  No



**Treatment history:**

Have you ever had any of the following treatments? When was your last treatment?

- Botox (How many Units?) \_\_\_\_\_ Last Treatment date: \_\_\_\_\_
- Filler (Which filler?) \_\_\_\_\_ Last Treatment date: \_\_\_\_\_  
Which part of the face?  
[ ] Nasolabial folds [ ] Lips [ ] Upper Cheeks [ ] Tear Troughs [ ] Forehead  
[ ] Crows Feet [ ] Jowls [ ] Eyebrow corners
- IPL (Foto Facial) Last Treatment date: \_\_\_\_\_
- Microdermabrasion Last Treatment date: \_\_\_\_\_
- Chemical Peel Last Treatment date: \_\_\_\_\_
- Micro Needling Last Treatment date: \_\_\_\_\_
- Laser Treatment Last Treatment date: \_\_\_\_\_
- Laser Hair Removal Last Treatment date: \_\_\_\_\_
- Waxing Last Treatment date: \_\_\_\_\_
- Fraction CO2 Last Treatment date: \_\_\_\_\_
- Cosmetic Surgery Last Treatment date: \_\_\_\_\_
- Keralase Last Treatment date: \_\_\_\_\_
- PRP Facial Last Treatment date: \_\_\_\_\_
- PRP hair restoration Last Treatment date: \_\_\_\_\_
- Sculptra Last Treatment date: \_\_\_\_\_
- PDO Threads Last Treatment date: \_\_\_\_\_
- PCDC / Kybella Last Treatment date: \_\_\_\_\_
- Micro needling + Radiofrequency (Genius RF) Last Treatment date: \_\_\_\_\_

Have you done any permanent makeup? If yes, when? \_\_\_\_\_

- No
- Eye Liner
- Lip Liner
- Full Lips



**Current concerns:**

What are your current skin concerns?

Please check all that apply:

- Fine lines and Wrinkles
- Redness
- Sagging Skin
- Deep lines
- Brown Spots
- Acne / Acne scars (please specify) \_\_\_\_\_
- Tone/Texture
- Pigmentation
- Other \_\_\_\_\_

What areas would you like to treat?

- Upper Face (please specify) \_\_\_\_\_
- Lower Face (lips, chin, jowls, under chin, neck) \_\_\_\_\_
- Body (chest, abdomen, bikini, back, armpits) \_\_\_\_\_
- Arms, legs, fingers, toes \_\_\_\_\_
- Other \_\_\_\_\_

List in order of importance the top 3 changes you would like to address with your skin.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_



Are you interested in hearing more about any of these services?

- Botox
- Fillers
- PRP (Plasma)
- Genius RF Microneedling
- Lase MD Ultra (Laser facial for skin tone and texture improvement)
- Keralase (Hair restoration)
- Sculptra
- Total Skin Rejuvenation (Genius RF Microneedling + Lase MD Ultra)
- PDO Threads
- Mini Face Lift
- PCDC / Kybella (Fat Melting under chin)
- Accufit Body Sculpting

Thank you for provided information! We are honored to be your care team and hope together we will achieve your desired results.

Please sign below and return this form to the front desk associate.

Signature: \_\_\_\_\_

Full Name: \_\_\_\_\_

Date: \_\_\_\_\_