



Patient Profile – Medical History

Name: _____ Sex: ____ Age: ____ Date of Birth: _____
 Address: _____ Daytime Phone: _____
 City: _____ State: ____ Zip: _____ Cell/Alt. Phone: _____
 E-mail address: _____ Today's Date: _____
 Emergency Contact (Name & Phone): _____
 How did you hear about Radiance and/or who Referred you: _____

(Please use the back of this form if the space provided anywhere is insufficient)

1. Have you ever had or have been treated for: ("X" all that apply)

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> AIDS/ARC | <input type="checkbox"/> allergy/hay fever | <input type="checkbox"/> dizziness/fainting spells | <input type="checkbox"/> epilepsy |
| <input type="checkbox"/> skin rash/disease | <input type="checkbox"/> asthma or wheezing | <input type="checkbox"/> head injury | <input type="checkbox"/> eye injury or disease |
| <input type="checkbox"/> heart trouble | <input type="checkbox"/> shortness of breath | <input type="checkbox"/> neuritis (nerve inflammation) | <input type="checkbox"/> swollen/painful joints |
| <input type="checkbox"/> cancer | <input type="checkbox"/> tuberculosis | <input type="checkbox"/> mitral valve prolapse | <input type="checkbox"/> rheumatism/arthritis |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> varicose veins | <input type="checkbox"/> drug or alcohol addiction | <input type="checkbox"/> tendonitis |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> phlebitis of vein | <input type="checkbox"/> frequent severe headaches | <input type="checkbox"/> bone or joint deformity |
| <input type="checkbox"/> bleeding problems | <input type="checkbox"/> back problem/pain | <input type="checkbox"/> nervousness | <input type="checkbox"/> ankle/feet swelling |

2. List other diseases or illnesses you have had:

3. List all prescription and non-prescription medication you are currently taking or have recently taken: ("X" all that apply)

- | | | |
|---|--|----------------------------------|
| <input type="checkbox"/> Heart | <input type="checkbox"/> Blood Pressure | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Insulin or other diabetic medications | <input type="checkbox"/> Tazorac | |
| <input type="checkbox"/> Cold / Allergy medications | <input type="checkbox"/> Testosterone / estrogen | |
| <input type="checkbox"/> Tranquilizers / Anti-depressants | <input type="checkbox"/> Antibiotics | |
| <input type="checkbox"/> Herbal / Nutritional supplements | <input type="checkbox"/> Vitamins | |
| <input type="checkbox"/> Retin-A / Renova / Differin / Hydroquinone | | |
| <input type="checkbox"/> Accutane – when stopped: | _____ | |
| List others: | _____ | |
| | _____ | |

4. List below all hospitalizations for illnesses, operations, accidents or fractures:

Year: _____ Reason: _____

 Year: _____ Reason: _____

 Year: _____ Reason: _____

 Year: _____ Reason: _____

5 Do you drink alcohol? Do you smoke?

- | | |
|--|---|
| <input type="checkbox"/> No | <input type="checkbox"/> No |
| <input type="checkbox"/> 1-2 drinks per week | <input type="checkbox"/> Less than 1 pack per day |
| <input type="checkbox"/> 3-5 drinks per week | <input type="checkbox"/> 1 pack per day |
| <input type="checkbox"/> 5+ drinks per week | <input type="checkbox"/> More than 1 pack per day |

6. Primary Physician: (Name and Telephone)

 Date of Last Physical? _____

7. When you go to the dentist:

- Do you require antibiotics be used? Y / N
 Do you require extra numbing medication? Y / N

8. Pharmacy Telephone: _____

Patient Name: _____

9. WOMEN ONLY:

Are you pregnant? Y / N Due Date: _____
Date of your last menstrual period: _____
Are you currently lactating? Y / N

10. Additional Questions:

Do you wear contacts? Y / N
(you may have to remove them for treatment)

11. Previous Cosmetic Procedures: ("X" all that apply)

Do you currently get/use: Facials / Peel Waxed Electrolysis Depilatories Microdermabrasion
Describe type(s), frequency & reaction(s): _____

Have you ever had laser resurfacing? Y / N When, Type & Depth? _____
Describe your reaction: _____

Have you had collagen/dermal filler injection(s)? Y / N When & Type? _____
Describe your reaction: _____

Have you had a Botox injection(s)? Y / N When/Frequency? _____
Describe your reaction: _____

Have you recently had facial or cosmetic surgery? Y / N When? _____
Describe: _____

12. Allergies:

Are you allergic/sensitive to? ("X" all that apply)

- Lidocaine Adhesives Latex Aspirin Perfumes Milk Eggs Hydroquinone
 Mushrooms Apples Grapes Citrus Aloe Vera Alcohol based products: _____
 Other: _____

List other allergies to any medication: _____

Have you every used any products that caused a bad reaction? Y / N
If yes, describe: _____

Have you ever seen a dermatologist or other physician for your skin? Y / N
If yes, describe: _____

Have you ever had a skin allergy or sensitivity? (Rash, irritation, peeling, swelling, hives, etc.)? Y / N
If yes, describe: _____

13. Skin Description: ("X" all that apply)

Describe your skin: Thick Thin Loose Firm Freckled
 Uneven/blotchy Normal Dry Oily Mature Wrinkled
 Melasma (mask of pregnancy) Rosacea Eczema Psoriasis Sun-damaged
 Hyper-pigmented (excess pigment) Hypo-pigmented (lack of pigment) Acne
 Dehydrated (lack of moisture) Patchy dryness on _____

Do you consider yourself: Sensitive to touch or pain Tolerant Resilient Not Sure

Skin tone: Pale/White Light Medium Reddish Freckled Lt. Olive
 Med. Olive Dark Olive Lt. Brown Med. Brown Dark Brown Soft Black Black

Describe your ethnic background? _____

Do you redden or flush easily when you eat spicy food, drink alcohol, get angry, go in the sun, etc.? Y / N

