

Patient Information and Medical History

Name _____ Sex _____ Today's Date _____

Date of Birth _____ Home Phone (____) _____ Cell (____) _____

Street Address _____ City _____

State _____ Zip _____ E-mail Address _____

Emergency Contact (Name, Phone, Relationship) _____

When calling regarding your appointments and procedures, which contact number should we use? Cell Home Other _____

How did you hear about us?

- RSVP Mailer Fiesta Magazine Health & Fitness North San Antonio Times Express News
- Radiance Website American Health & Beauty Website Internet Search (specify) _____
- Client Referral (specify) _____ Walk-In Other _____

1. Please list any food or drug **allergies or sensitivity**: _____

2. Have you ever used/are you currently using any of the following? (check all that apply)

- Retin A Renova Accutane Prescription Acne Medicine Steroids
- Birth Control Pills or Depo Shot

3. Please list all prescription and non-prescription medication or herbal supplements that you are currently taking: _____

4. Please list any chronic conditions that are currently treated by your primary care provider: _____

5. Please list any past hospitalizations or surgeries: _____

6. Please list any past cosmetic facial treatments or surgeries and any complications or reactions: _____

7. Do you smoke? No Less than 1 pack per day 1 pack per day More than 1 pack per day

8. Do you drink? No 1-2 drinks per week 3-5 drinks per week 5+ drinks per week

9. Women, what is the date of your last menstrual cycle? _____

Are you pregnant? Yes No Are you lactating? Yes No

10. Have you ever had cold sores or fever blisters? Yes No

How Often? _____

11. Have you ever had or been treated for: (check all that apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Headaches/Migraine | <input type="checkbox"/> Radiation |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Sinus Infection |
| <input type="checkbox"/> Arthritis/Joint Pain | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Skin Rash/Disease |
| <input type="checkbox"/> Asthma/Respiratory Problems | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> STDs |
| <input type="checkbox"/> Back Pain/Spinal Injury | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Blood Disease/Hypertension | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Blood Transfusions | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Lupus | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Melanoma | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mental Disease | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Neuritis | _____ |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Pacemaker/Defibrillator | _____ |
| <input type="checkbox"/> Hay Fever/Allergies | <input type="checkbox"/> Phlebitis of Vein | |

12. Which areas are you interested in improving and which procedures are you interested in learning more about?

- | | |
|---|--|
| <input type="checkbox"/> Cellulite | <input type="checkbox"/> Botox |
| <input type="checkbox"/> Hair Reduction | <input type="checkbox"/> Dermal Fillers |
| <input type="checkbox"/> Wrinkles | <input type="checkbox"/> Facials/Peels |
| <input type="checkbox"/> Skincare (please specify): | <input type="checkbox"/> IPL Skin Rejuvenation |
| <input type="checkbox"/> Acne | <input type="checkbox"/> Massage Therapy |
| <input type="checkbox"/> Pigmentation | <input type="checkbox"/> Microdermabrasion |
| <input type="checkbox"/> UV Damage | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Texture | |

_____ I understand that the information on this form is essential to determine my medical and cosmetic needs and the provision of treatment. I will report any changes in my medical condition to the office staff as soon as possible. I have read the above questionnaire and acknowledge that all answers have been recorded truthfully and will not hold any staff member responsible for any errors or omissions I may have made in completion of this form.

_____ I understand that a \$25 fee will be charged for each additional half hour consultation, which may be credited to any Radiance product or service.

_____ I understand that if I do not provide a 24 hour cancellation notice for a scheduled procedure, except in the case of an emergency, I will be responsible for payment in full of the scheduled service.

Patient Signature

Date

Witness Signature

Date