



## Patient Information and Medical History

Name \_\_\_\_\_ Sex \_\_\_\_\_ Today's Date \_\_\_\_\_

DOB (mm/dd/yy) \_\_\_\_\_ Home (\_\_\_\_) \_\_\_\_\_ 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?

Express News/STAR  Radiance Website  San Antonio Current  Military Guide  Radiance Website

Internet Search (specify keyword used) \_\_\_\_\_  Walk-In  Other \_\_\_\_\_

Client Referral (specify) \_\_\_\_\_

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 had a mammogram?  Yes  No What was the date of your last mammogram? \_\_\_\_\_

11. Have you ever had cold sores or fever blisters?  Yes  No If so, how often? \_\_\_\_\_

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

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

13. Do you have a **family history** of adverse reactions to surgery or anesthesia, including allergic reactions, blood clots, or pulmonary embolism? Yes No

14. Do you have a family history of diabetes, heart disease, liver disease, breast cancer, or any other type of cancer. Yes No Please circle those that apply.

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

- |   |  |
|---|--|
| <input type="checkbox"/> Breast Augmentation  | <input type="checkbox"/> Botox/Dermal Fillers    |
| <input type="checkbox"/> Tummy Tuck   | <input type="checkbox"/> Facials/Peels           |
| <input type="checkbox"/> SmartLipo  | <input type="checkbox"/> Laser Skin Rejuvenation |
| <input type="checkbox"/> Cellulite Reduction  | <input type="checkbox"/> Massage Therapy         |
| <input type="checkbox"/> Hair Reduction   | <input type="checkbox"/> Microdermabrasion       |
| <input type="checkbox"/> Wrinkles   | <input type="checkbox"/> Other _____             |
| <input type="checkbox"/> Skincare (please specify): <input type="checkbox"/> Acne <input type="checkbox"/> Pigmentation <input type="checkbox"/> UV Damage <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 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 a \$50 no show fee.

**\*\*\*I acknowledge that I have received and read the Notice of Privacy Policy and Procedures which accompanies this intake form and that I have had any questions regarding this notice answered to my satisfaction.\*\*\***

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date