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?

□Radiance Website □San Antonio Current □Military Guide □Walk-In □Other_____

Internet Search: Botox_____ Juvederm_____ MedSpa_____ Other (please specify)_____

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 ever had cold sores or fever blisters? Yes __No ___If so, how often? _____

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

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

12. Do you have a family history of adverse reactions to surgery or anesthesia, including allergic reactions, blood clots, or pulmonary embolism? Yes____ No____

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

	Botox/Dermal Fillers
Tummy Tuck	Facials/Peels
SmartLipo	Laser Skin Rejuvenation
Cellulite Reduction	Microdermabrasion
Hair Reduction	Other _____
Wrinkles	

Skincare (please specify): □Acne □Pigmentation □UV Damage □Texture

14. I agree to the transmission to me by email of my health information not encrypted upon my request or in response to my email inquiries to Radiance. I understand Radiance will use reasonable practice to ensure security of such information but cannot guarantee such security. I, for myself, my heirs, executors, administrators and assigns, fully and forever release and discharge **Radiance Medspa** and its affiliates, shareholders, officers, directors, physicians, agents and employees, from and against any and all losses, claims, and liabilities arising out of or connected with the use of such e-mail.

Yes and e-mail_____ No_____ Email:_____

_____ 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

_____ _____
Dr. Laura Bennack Date