New Radiance Medical and Aesthetics

Patient Information

Patient information as of today's date: _____
(Please print legibly and fill in all fields. If information is not available, please put N/A.)

Personal Information

Patient Name _____ SSN:_____ DOB _____

- Address _____ Apt# _____

City _____ State _____ Zip _____

Cell Phone (_____)_____ Home Phone (_____)_____

Work Phone (_____)_____ Email Address _____

Occupation _____ Employer _____

Preferred Language _____ Sex: € Male € Female

Emergency Contact Name/Phone Number _____ # (_____)_____

Reason for your visit today?

_____

Date of last physical _____ Name of Primary Physician _____

Is your general health good? € Yes € No

Allergies? € Yes € No Known Drug Allergies

If yes, please list: _____

List all medications you are taking (prescription and OTC):

_____

_____

Do you take Aspirin, Advil, Motrin, Ibuprofen or anti-inflammatory medication more than once per week?

€ Yes € No If yes, please explain: _____

Do you smoke? € Yes € No If yes, how many per day/for how many years: _____

Do you drink alcohol? € Yes € No If yes, how much/how often: _____

Do regularly use a tanning bed or sun exposure? € Yes € No If yes, how much/how often: _____

Do regularly take vitamins? € Yes € No If yes, what kind and how often: _____

Are you currently pregnant? € Yes € No Are you currently breastfeeding? € Yes € No

Are you currently trying to become pregnant? € Yes € No

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Present/Past Medical History

Have you ever had any of the following (please check all that apply):

€ Asthma	€ Arthritis	€ Anemia
€ Autoimmune disorder	€ Blood disorder	€ Chest Pain
€ Chronic diarrhea	€ Clotting disorder	€ Colon problems
€ Diabetes	€ Depression	€ Easily Bruise
€ Excessive scarring	€ Excessive bleeding	€ Heart Attack
€ Heart valve disease	€ Heart valve replacement	€ Heart Failure
€ High/ low blood pressure	€ Hepatitis	€ HIV
€ Irregular heart beat	€ Intestinal problems	€ Keloids
€ Kidney disease	€ Liver disease	€ Lung disease
€ Multiple Sclerosis	€ Muscular Dystrophy	€ MVP
€ Migraines	€ Rheumatic fever	€ Shortness of breath
€ Seizures	€ Stomach problems	€ Varicose veins
€ Unusual mole	€ Tattoo/ permanent makeup	€ Stroke
€ Thyroid disorder		

€ Cancer: Please list type: _____

Please list all surgeries or hospitalizations with dates:

_____Date_____
_____Date_____
_____Date_____
_____Date_____

Please list any cosmetic procedures you have had (surgical and non-surgical) with dates:

_____Date_____
_____Date_____
_____Date_____
_____Date_____

Please describe your current skin care process

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Please list any substances that irritate your skin

Please list any concerns that you have?

Please list any treatments or products that interest you.

To the best of my knowledge, the information provided above is true and accurate. I agree to tell the staff of any changes to my health history or medications as they arise. I understand that information is necessary for your practice and will remain confidential. All efforts are routinely made to ensure privacy is upheld.

Printed Patient Name **Date** **Signature of Patient**

Practice Representative Name **Signature of Practice Representative**