Patient Profile- Medical History

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

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

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

List other diseases or illnesses you have had:

_____
_____

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

Year:_____ Reason:_____
Year:_____ Reason:_____
Year:_____ Reason:_____
Year:_____ Reason:_____

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

☐Heart ☐Blood Pressure ☐Thyroid ☐Vitamins
☐ Insulin or other diabetic medication
☐Tazorac ☐Testosterone/Estrogen ☐Antibiotics
☐Cold/allergy medications
☐Asprin/Ibuprofen/Advil/Motrin/Aleve
☐Tranquilizers/anti-depressants
☐Herbal/Nutritional Supplements
☐Retin-A/Renova/Differin/Hydroquinone
☐Accutane- when stopped?_____
☐ Other _____

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

When you go to the dentist:
Do you require antibiotics to be used? **Y/N**
Do you require extra numbing medication? **Y/N**

Primary Physician: (name and telephone)
_____
Date of last physical:_____
Pharmacy telephone: _____

Women Only:
Are you pregnant? **Y/N** Due Date:_____
Date of your last menstrual period: _____
Are you currently nursing? **Y/N**

Do you drink alcohol?
- ☐ No
- ☐ 1-2 drinks per week
- ☐ 3-5 drinks per week
- ☐ 5+ drinks per week

Do you smoke?
- ☐ No
- ☐ Less than 1 pack a day
- ☐ 1 pack per day
- ☐ More than 1 pack a day

Are you allergic/sensitive to? ("X" all that apply)
☐Lidocaine ☐Adhesives ☐Latex ☐Aspirin
☐Perfumes ☐Milk ☐Apples ☐Grapes
☐Eggs ☐Mushrooms ☐Hydroquinone
☐Alcohol based products ☐Citrus ☐Aloe

_____ _____
Patient Signature **Date** **Clinician Signature** **Date**

This is a confidential report of your medical history and will be kept in this office. Information contained herein will not be released to any person or organizations except when you have authorized us to do so.