RAD

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RAD Patient Health Information

Name: _____ Date: _____

Address: _____

Email_____

Phone: _____ Alt. Phone: _____

Date of Birth: _____

How did you hear about us?_____

If referral, who? _____

CLIENT PAST MEDICAL HISTORY

Do you have any of the following SKIN conditions:

___ Acne
___ Rosacea
___ Eczema
___ Psoriasis
___ Dry Scalp
___ Other _____

Do you have any of the following MEDICAL conditions:

___ AIDS/Immume Disease
___ Arthritis
___ Asthma/Hay Fever
___ Blood Disease
___ Chemotherapy
___ Diabetes
___ Fainting
___ Heart Disease
___ Hepatitis or Liver Disease
___ High Blood Pressure
___ Kidney Disease
___ Infection (active)
___ Lupus
___ Radiation Treatment
___ Respiratory Issues
___ Sinusitis
___ Stomach Problems

Allergies:

__ Milk __Aspirin __Strawberries __Sugar Cane

Medications:_____

Cosmetics: _____

Latex/other: _____

Have you ever/are you currently using:

___ Retin-A, Renova, retinoic acid products
___ Accutane
___ Other Acne Medication
___ Birth Control pills
___ Steroids
___ Topical Cortisone
___ Are you pregnant (due date if you are)
___ Are you lactating?

Previous Cosmetics Facial Treatments:

___ Chemical Peel
___ Botox
___ Collagen
___ Electrolysis
___ Tattoo/Perm. Makeup
___ Waxing
___ Facial Surgery
___ Laser Surgery
___ Microdermabrasion

Have you ever had:

___ Cold sore
___ Fever blister

If yes, frequency: <1/year 1-3/year 3-5+/year

List all the current medications that you take:

_____

What should we know about your goals for your skin treatment program:

_____