

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/Immune 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:
