Patient Profile - Medical History

Name: _____ Sex ___ Age _____ Date of Birth: _____ Today's Date: _____

Address: _____ Daytime Phone: ☐ _____

City: _____ State: _____ Zip: _____ Cell/Alt Phone: ☐ _____

Is it ok to leave messages or contact you at the preferred number (☐) selected above? Y / N

E-mail: _____

Emergency Contact: _____ Phone Number: _____

How did you hear about Radiance? _____

1. Have you ever had or been treated for? *("X" all that apply)*

☐ AIDS/HIV	☐ Abdominal surgery	☐ Anemia	☐ Bell's Palsy
☐ Bleeding problems	☐ Cancer	☐ Diabetes	☐ Dizziness / Fainting
☐ Epilepsy	☐ Epstein Barr	☐ Eye Injury or Disease	☐ Frequent/Severe headaches
☐ Glaucoma	☐ Hepatitis	☐ Hernia	☐ Herpes Simplex Virus
☐ Heart trouble	☐ High blood pressure	☐ Liver problems	☐ Lambert Eaton Syndrome
☐ Multiple Sclerosis	☐ Myasthenia Gravis	☐ Neurological Disorders	☐ Rheumatism / Arthritis
☐ Rosacea	☐ Skin Cancer	☐ Skin Rash/disease	☐ Metal/Electronic Implants/Devices

2. List any other diseases or illnesses you have had: _____

_____

3. Select all prescription and non-prescription medication you are currently taking or have recently taken:

☐ Accutane	☐ Antibiotic	☐ Aspirin / Advil / Aleve / Ibuprofen	☐ Blood Thinners
☐ Estrogen	☐ Fish Oil / Omega 3	☐ Retin-A / Hydroquinone	☐ Vitamin E

☐ Vitamins (list all): _____

☐ Herbal Supplements (list all): _____

☐ List all medications including eye drops: _____

☐ I am NOT taking any supplements or medications currently

4. Date of last physical: _____ **List any abnormal findings:** _____

5. Do you smoke? Y / N **Number of alcoholic drinks per week:** _____

6. Have you ever had surgery? Y / N If yes, have you ever had complications healing after surgery? Y / N

Describe Type: _____

7. WOMEN ONLY

Are you pregnant? Y / N Are you currently lactating? Y / N Date of last period: _____

8. Previous Cosmetic Procedures:

- Have you recently had a Facial / Microdermabrasion / Chemical Peel? *(Circle all that apply)*
- Have you had BOTOX or Dermal filler injection(s)? Y / N When: _____ Type: _____
- Have you had Laser Treatments? Y / N When: _____ Type: _____
- Have you had facial/cosmetic surgery? Y / N When: _____ Type: _____

9. Have you ever seen a dermatologist/physician for your skin? Y / N

If yes, describe: _____

(Please continue onto the other side of this page)

10. **Allergies:**
    - List any allergies to medications: _____
    - Are you allergic to or have you ever had a bad reaction to Lidocaine? Y / N
      If yes, describe: _____
    - Have you ever had a bad reaction to adhesives / latex / Band-aids? Y / N
      If yes, describe: _____
    - Have you ever had a skin allergy or sensitivity (rash, irritation, swelling, and hives)? Y / N
      If yes, describe: _____
11. **When you go to the dentist:** Do you require antibiotics? Y / N
    Do you require extra numbing medication? Y / N
    Have you had dental work or cleaning in the last 4 weeks? Y / N
    Any dental procedures/cleanings scheduled in the next 4 weeks? Y/N
12. **Have you ever had a "cold sore"?** Y / N If yes, describe: _____
13. **Skin Description:**
    Describe your ethnic background: _____
    How do you tan? ☐ Burn ☐ Usually Burn ☐ Sometimes Burn ☐ Rarely Burn ☐ Never Burn
14. **Do you use sun block regularly? Y / N**
15. **What skin care products do you currently use?**
16. **Desired Improvements:** _____
17. **List any current appearance concerns / interests that brought you to Radiance Medspa:**
    - _____
    - _____
    - _____
    - _____
    - _____
18. **What procedures would you like to learn more about?** *("X" all that apply)*

☐ BOTOX/Juvederm	☐ Coolsculpting	☐ Vivace	☐ Peels/Facials
☐ IPL Photo Rejuvenation	☐ Laser Hair Removal	☐ Icon Eraser Laser	☐ Skin Care Products
☐ Laser Liposuction	☐ PRP/PRP Hair Again	☐ CoolTone	☐ CO2 Laser / CoolPeel

☐ Other: _____

19 **Have you ever taken the following medications:**

☐ Xanax (Alprazolam)	☐ Vicodin (Hydrocodone)	☐ Ativan (Lorazepam)	☐ Percocet (Oxycodone)
☐ Keflex (Cephalexin)	☐ Valtrex / Acyclovir	☐ Any antibiotics	☐ Lidocaine

20 **Please explain any adverse reactions you've had to any of the medications listed above:** ☐ None

_____
_____
_____

Please initial:

_____ I have been provided with a copy of the Radiance Medspa HIPAA Privacy Policy.

_____ _____
Patient Signature Date

_____
Patient Name

radiance™ medspa
There's a younger you inside℠

Radiance Appointment Policies

Appointment Deposits: Some appointments require deposits at the time of booking services, **appointments must be secured with a minimum $75 deposit, unless listed below.** Appointment deposits are non-refundable and serve to reserve our medical staff and our equipment specifically for you and your treatment. Any changes or cancellations to these appointments without the required amount of notice will forfeit the deposit in its entirety and maybe subjected to additional fees. Appointments may be changed without penalty if the minimum amount of notice is provided, per the table below.

Arrival Time: Please arrive 15 minutes prior to your appointment to complete paperwork and get checked in so that your treatment can begin on time. We will do everything we can to accommodate late arrivals, however, if we do not have enough time to provide a quality treatment without impacting other patient appointments, we may need to cancel your appointment and reschedule. **Late arrival cancellations will forfeit the appointment deposit.**

Changes, Cancellations, and No-Shows: Most appointments must be secured with a deposit. The appointment deposit will be forfeited for any no shows and for any changes or cancellations made within 24 hours. Appointments that require payment in full prior to treatment are subject to other specific cancellation policies listed below in the "Appointment Details" section. Any outstanding late fees on your account will need to be paid at the time of your next re-booking.

	Non-Refundable Deposit Required	Min Change /Cancellation Notice Required
Coolsculpting	Payment in Full	48 hours
Lasers, Vivace, CO2	Payment in Full	48 Hours
Juvederm Filler	$75 Deposit	48 Hours

Payments: Payments must be made in full at the time services are rendered. We accept Cash, All Major Credit Cards, Checks with valid ID, and valid Gift Cards. We also accept Care Credit patient financing for patients who wish to finance their purchases. A returned check fee of $35 will be charged for any returned checks.

Expiration: All service purchases expire 12 months after the date of purchase and are non-refundable and non-transferrable.

Refunds: All sales are final. This includes purchases of products and services as well as appointment deposits. If you no longer wish to use your appointment deposit towards the intended treatment, it will become a credit, good for 12 months from the date of purchase, for use towards other Medspa products or services.

Patient Consent: I hereby acknowledge that I understand and accept the polices above are effective immediately and for the duration of time that I am a patient at Radiance Medspa.

Patient Signature/Date _____ **Printed Name** _____