



Client Profile

Name: _____ Sex: _____ Age: _____ Date of Birth: _____

Address: _____ Daytime Phone: _____

City: _____ State: _____ Zip: _____ Cell Phone: _____

Email Address: _____ Today's Date: _____

How did you hear about Radiance or who referred you? _____

Emergency Contact: _____ Phone: _____

Have you ever been treated for: (Check all that apply)

- AIDS/HIV
- Skin rash/disease
- Heart problems
- Cancer
- Diabetes
- High blood pressure
- Allergies/hay fever
- Asthma or wheezing
- Lung Problems
- Tuberculosis
- Varicose Veins
- Low immunity
- Dizziness/fainting
- Bleeding problem
- Nervousness/Anxiety
- Claustrophobia
- Drug/alcohol addiction
- Severe Headaches
- Seizures
- Eye problem
- Back pain
- Arthritis
- Head Injury
- Cold Sores

List any other diseases or illnesses you have had:

List all prescription and OTC Medications you are currently using or have recently used:

- Heart
- Thyroid
- Blood Pressure
- Vitamins
- Tazorac
- Cold/Allergy
- Insulin/other diabetic meds
- Antidepressants/ Anxiety Meds
- Herbal/nutritional supplements
- Retin-A/Renova/Differin
- Hydroquinone
- Testosterone/estrogen
- Antibiotics
- Accutane-when stopped _____
- Others: _____

Do you drink alcohol? Yes No Do you smoke? Yes No Do you wear contact lenses? Yes No

Have you ever had a cold sore? Yes No If yes, explain: _____

Do you require antibiotics when you go to the dentist? Yes No

WOMEN ONLY Date of Last Menstrual Period _____ Are you pregnant? Yes No Due Date: _____

Previous Cosmetic Procedures:

Waxing/electrolysis/use depilatories? Yes No When & What kind? _____

Microdermabrasion Yes No When & How often? _____

Laser Resurfacing Yes No When? _____

Dermal Filler Injection Yes No When & Which type? _____

Botox Injection Yes No When? _____

Chemical Peel Yes No When & What kind? _____

Facial or Cosmetic Surgery Yes No Describe: _____

Allergies:

List: _____

Have you ever had a bad reaction to any skincare products? _____ Describe: _____

Have you ever seen a dermatologist for your skin? _____ If yes, why? _____

Skin Description:

Describe your ethnic background: _____

Do you use sunscreen regularly? Yes No Do you use tanning booths or lotions? Yes No

How do you tan? _____ Do you burn easily in the sun? Yes No

Have you or anyone in your family had skin cancer? Yes No Describe: _____

Describe your current skincare regimen: _____

Desired Improvements:

Current appearance problems/goals that brought you to Radiance Medspa: _____

Client Signature/Date

Clinician Signature/Date