RADIANT DERMATOLOGY

NAME _____ **DOB** _____/_____/_____

Male/Female Social Security Number _____-_____-_____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Race: ☐ White ☐ Black or African American ☐ American Indian/Alaskan Native

☐ Native Hawaiian/Other Pacific Islander ☐ Other _____

Address _____

City _____ State_____ Zip Code _____

Primary Phone Number _____ home / cell

Secondary Phone Number _____ home / cell

E-mail address _____

Employment Status: ☐Retired ☐Unemployed ☐Full-time ☐Part-time ☐Student

Employer _____

Employer Phone Number _____

Emergency Contact

Name _____ Phone number _____

Relationship _____

Primary Care Physician _____

Location _____

Preferred pharmacy _____

Pharmacy Zip Code _____

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NAME_____

Patient Medical History

Do you have now, or have you ever had diseases or conditions of (please check if applies):

☐ Anxiety/Depression	☐ Blood Clots	☐ Dizzy Spells
☐ Arthritis	☐ Bleeding Disorder	☐ Fainting
☐ Asthma/Wheezing	☐ Pacemaker	☐ Lung Disease
☐ Irregular Heartbeat	☐ Swelling Hands/Feet	☐ Kidney Disease
☐ Heart Murmur	☐ Diabetes	☐ Liver Disease
☐ Heart Attack	☐ High Blood Pressure	☐ Eye Disease
☐ Seizures/Epilepsy/Convulsions	☐ Stroke	

Other:_____

Please list any surgeries in the past 6 months: _____

_____

Skin Disease History

☐ Acne	☐ Basal Cell Cancer	☐ Squamous Cell Cancer
☐ Precancerous Moles	☐ Melanoma	☐ Blistering Sunburns
☐ Actinic Keratoses	☐ Dry Skin	☐ Eczema
☐ Psoriasis	☐ Keloids/Scars after Surgery	

Other:_____

Do you wear Sunscreen?	☐ Yes ☐ No	If yes, what SPF? _____
Do you tan in a tanning salon?	☐ Yes ☐ No	
Family History of Melanoma?	☐ Yes ☐ No	Relation: _____

Medications: ☐ NONE
(Please provide name and dosage—if you have a list, we will happily make a copy)

_____

_____

_____

_____

_____

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Allergies: ☐ No Known Drug Allergies
(Please provide causative medication and reaction)

Social History
Do you smoke? ☐ Current ☐ Former ☐ Never If current, how much?_____
Do you drink alcohol? ☐ Yes ☐ No If yes, how much?_____

Family Medical History
(parents and siblings only):

How did you hear about Radiant Dermatology?

☐ Doctor:_____ ☐ Friend:_____

☐ Insurance ☐ Internet/Website

☐ Magazine Ad (which one?):_____

☐ Other: _____

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Name _____

Review of Systems: Are you currently experiencing any of the following? If so, please check the corresponding box.

☐ Problems with healing/bleeding
☐ Rash
☐ Hay Fever
☐ Fever/Chills
☐ Unintentional Weight Loss
☐ Sore Throat
☐ Abdominal Pain
☐ Joint Aches
☐ Neck Stiffness
☐ Seizures
☐ Shortness of Breath
☐ Anxiety
☐ Problems with Scarring
☐ Immunosuppression
☐ Chest Pain
☐ Night Sweats
☐ Thyroid Problems
☐ Blurry Vision
☐ Bloody Stool or Urine
☐ Muscle Weakness
☐ Headaches
☐ Cough
☐ Wheezing
☐ Depression

Other symptoms: _____

Alerts:
☐ Allergy to Adhesive
☐ Allergy to Lidocaine
☐ Allergy to topical antibiotics
☐ Artificial heart valve
☐ Blood thinners
☐ Pregnant (_____wks)
☐ MRSA
☐ Pacemaker
☐ Require antibiotics prior to surgery
☐ Rapid heart beat with epinephrine
☐ Defibrillator
☐ Breastfeeding