Radiant
SKIN AND LASER CENTER

Name _____ Date _____

Home Address _____ City _____

Zip Code _____ Email Address _____

Home Phone _____ Cell Phone _____

DOB _____ How were you referred to us? _____

Within the last year, any surgeries or health problems? _____

Medications: _____

Allergies: _____

Do You Smoke? Y/N Wear Contacts? Y/N Tan? Y/N

Are you pregnant? Y/N Taking Oral Contraception? Y/N

Do you use Retin-A, Renova, Accutane or any other skin RX? _____

What are your Skin Care goals? _____

What Skin Care Products are you currently using? _____

Cleansers? _____ Moisturizers? _____

Do you experience breakouts? Y/N Flakiness? Y/N Tightness? Y/N

How much water do you consume daily? _____

How many caffeinated beverages do you consume daily? _____