The Skin Center Wailea

161 Wailea Ike Place, Suite D 102 808-875-7030

Medical History Intake form:

Last Name:_____First Name:_____

Address:_____

City_____State:_____zip code:_____

Cell/ Phone #_____Email:_____

Date of Birth:_____/_____/_____ Sex: Female_____ Male_____

Family Doctor:_____

Emergency Contact:_____Cell/ Phone#_____

What treatments or services are you interested in receiving / discussing.

_____

_____

_____

Please answer all of the following questions, **circle yes or no**:

1. Do you have ANY current or chronic medical illnesses? Yes No

   (Disclose any history of heat urticarial, diabetes, autoimmune disorders or any immunosuppression, blood disorders, cancer, bacterial or viral infections, medical conditions that significantly compromise the healing response, skin photosensitivity disorders, seizures, or any other condition or illness.)

   Please List:_____

2. Do you have any current or chronic skin conditions? Yes No

(Disclose and history of vitiligo, eczema, melasma, psoriasis, allergic dermatitis, any diseases affecting collagen including Ehlers-Danlos syndrome, scleroderma, skin cancer, or any other skin condition.

Please list:_____

3. Are you currently under a doctor's care? If so, for what reason? Yes No

Please List:_____

4. Do you take / use ANY medications (prescription and nonprescription), vitamins, herbal or natural supplements, on a regular basis? Yes No

Please List:_____

5. Are there ANY topical products (both Medical and Non-Medical) that you use on your skin on a regular or daily basis? Yes No

Please
List:_____

6. Do you take ANY systemic / oral steroids (e.g., Prednisone, Dexamethasone?)

Yes No

7. Do you have ANY allergies to medications, food, latex or any topical substances?

Yes No

` Please list:_____

8. Do you have a history of herpes 1 or herpes 2 in the area being treated?

Yes No

9. Do you have a history of keloid scarring or hypertrophic scar formation?

Yes No

10. Do you have a history of light induced seizures? Yes No

11. Do you have any open sores or lesions? Yes No

12. Do you have a History or radiation therapy in the treatment area? Yes No

13. In the last 6 months, have you used any of the following: Anticoagulants or Blood thinners, photosensitizing medications or **Fish Oil**, Anti-inflammatory medication including Ibuprofin-alieve-Asprin? Yes No

Please List:_____

14. In the last 3 months have you used any of the fallowing products:

Gylcolic acid or other Alpha Hydroxy or Beta Hydroxy Acid products: Exfoliating, chemical peels or resurfacing treatments. Yes No

Please list:_____

15. Do you have or ever had any permanent make-up, tattoos, implants, or fillers, including but not limited to, collagen, autologous fat, Restylane, Juvederm, Yes No

Please list which, the area and the date you received:_____

_____

16. Do you have or have you ever had any Botulinums, such as Botox or Dysport?

Yes No

Please list locations and dates when received:_____

17. In the last 12 months have you taken Acutane or products containing isotretinoin for Acne? Yes No

18. In the last 6 months have you used retinol or retin- A (Tretinoin) Yes No

19. Have you had unprotected sun exposure, used self-tanning lotions or creams, tanning beds or lamps in the last 4-6 weeks? Yes No

20. Please list any skin care product s you are currently using:

_____
_____
_____
_____
_____

Signature_____Date_____