Ali'i Nani Aesthetic Medicine

Medical History

Today's Date: _____ Email:_____Date of Birth:_____

Last Name:_____ First Name:_____M:_____

How did you hear about us?_____

Ethnicity:_____

Address:_____

Telephone:_____ Cellphone:_____ Sex: __ F __M

Family Doctor:_____ Phone:_____

Emergency Contact:_____Phone:_____

Which body area/areas or condition would you like treated?_____

Have you had these areas/conditions treated before?___ Yes ___No

If yes, how many times have you had these areas/ conditions treated previously?_____

If yes, what was the result or your experience?_____

Do you have any of these medical conditions whether current, chronic or history that may compromise healing process? (check all that applies):

__Heat urticaria __Diabetes __Autoimmune disorders __Blood disorders
__Cancer __ Bacterial/Viral Infections

Others:_____

Do you have any of these skin conditions whether current, chronic or history (check all that applies):

__Vitiligo __Eczema __Melasma __Psoriasis __Allergic Dermatitis
__Skin cancer __Scleroderma

Others:_____

Are you currently under a doctor's care? __Yes __No

If so, for what reason?_____

_____

Are you taking/using any systemic/oral steroids (prednisone, dexamethasone? __Yes __No

(Women) Are you or could you be pregnant?	__Yes	__No
(Women) Are menstrual periods regular?	__Yes	__No
(Women) Have you been diagnosed with Polycystic Ovarian Disorder?	__Yes	__No
Do you have history of cold sores or fever blisters?	__Yes	__No

Do you have history of keloid scarring? __Yes __No
Do you have history of light-induced seizures? __Yes __No
Do you have any open sores or lesions? __Yes __No
Do you have history of radiation therapy in the area to be treated? __Yes __No
In the last six months, have you used any of the following: __Yes __No
anticoagulants or blood-thinning medications, photosensitizing
medications, anti-inflammatories? Please list product name and date last used:_____

_____

In the last 3 months, have you used of the following products? __Yes __No
glycolic acid or other alphahydroxyacid or betahydroxyacid products,
exfoliating or resurfacing products or treatments? Please list product name and date last used:_____

_____

Do you have or have you ever had any permanent makeup, tattoos, __Yes __No
implants, fillers. including but not limited to collagen, autologous fat,
Restylane, etc? Please list locations on the body and dates:_____

_____

Do you have or have you ever had Botox or Dysport? __Yes __No
Please list location on body and dates:_____

_____

Have you taken Accutane or products containing isotretinoin __Yes __No
in the last 12 months?
Have you taken Tretinoin like Retin-A or Renova in the last 6 months? __Yes __No
Have you had any unexpected sun exposure, used tanning creams, __Yes __No
used sunless tanning lotions or tanning beds/lamps in the last 4-6 weeks?

Signature:_____ Date:_____