MEDISPA MAUI
SKIN CARE & LASER CENTER

# Medical History

Please review the list below and circle "Y" or "N" as to whether you have in the past or are currently experiencing any of the following conditions/products:

| | | | | | |
|---|---|---|---|---|---|
| Arthritis | Y | N | Permanent Makeup | Y | N |
| Hepatitis | Y | N | If Yes, Location_____ | | |
| Heart Problems | Y | N | Contact Lenses | Y | N |
| Diabetes | Y | N | History or Family History of | Y | N |
| Cold Sores/Herpes | Y | N | Skin cancer/Melanoma | | |
| If Yes, location_____ | | | Treatment of Rosacea | Y | N |
| Fainting | Y | N | If Yes, Treatment_____ | | |
| HIV | Y | N | Recent Sun Exposure | Y | N |
| Reaction to Topical Anesthetic | Y | N | If Yes, Date_____ | | |
| Keloids or Scarring | Y | N | Treatment with Accutane | Y | N |
| Melasma/Pigmentation | Y | N | If Yes, Dates_____ | | |
| Brown or White Discoloration | Y | N | Use of Retin-A/Renova | Y | N |
| From burns/scrapes | Y | N | Use of Alpha Hydroxy Acids | Y | N |
| Pregnancy | Y | N | Use of Glycolic Acid products | Y | N |
| Lupus | Y | N | | | |

Allergies: (Please list)

_____

Medical History:

_____

_____

Present Medications:

_____

Previous Surgical Procedures: (Include Dates, Complications)

_____

_____

Patient Signature: _____ Date: _____

Practitioner: _____ Date: _____