



PATIENT INFORMATION FORM

PATIENT DATA

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____ Social Security: _____ Gender: Female Male

ADDRESS

Address: _____

City: _____ State: _____ Zip: _____

PHONE

Home: _____ Work: _____ Mobile: _____

EMAIL

Email: _____
Your email will be used for internal communications from our office only. We will NEVER sell your personal information

What is your preferred contact method? Please circle one **Phone** **Email** **Letter**

RESPONSIBLE PERSON • PATIENTS 18 & UNDER ONLY

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____

City: _____ State: _____ Zip: _____

EMERGENCY CONTACT

Last Name: _____ First Name: _____ Home Ph: _____

REFERRAL

How did you hear about us? _____

Please leave blank to be filled out by office staff

Insurance: _____	CPT CODES
Copay: _____ Deductible: _____	
Follow Up: _____ RF <input type="checkbox"/>	



PATIENT HEALTH QUESTIONNAIRE

All information collected in this questionnaire is strictly confidential and will become part of your medical record. Please bring this completed form with you to your consultation

PATIENT DATA

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Occupation / Employer: _____

Primary Care Physician: _____ Referring Physician: _____

Ethnicity:

- Hispanic or Latino
- Not Hispanic or Latino
- Unknown

Race:

- White
- American Indian or Alaska
- Asian
- Black or African American
- Native Hawaiian or Pacific Islander
- Other

What are you seeing the dermatologist for today? _____

PAST MEDICAL HISTORY

Have you had any of the following conditions?

- | | | |
|--|--|--|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Hyperthyroidism |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Depression | <input type="checkbox"/> Hypothyroidism |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> End Stage Renal Disease | <input type="checkbox"/> Lung Cancer |
| <input type="checkbox"/> Atrial Fibrillation (Irregular Heartbeat) | <input type="checkbox"/> GERD | <input type="checkbox"/> Lymphoma |
| <input type="checkbox"/> BPH | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Prostate Cancer |
| <input type="checkbox"/> Bone Marrow Transplantation | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Hypercholesterolemia | |

Other: _____

PAST SURGERIES

Have you had any previous surgeries? If so, what and when? _____

SKIN DISEASE HISTORY

Have you had any of the following conditions?

- | | | |
|---|---|--|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Dry Skin | <input type="checkbox"/> Poison Ivy |
| <input type="checkbox"/> Actinic Keratoses | <input type="checkbox"/> Eczema | <input type="checkbox"/> Precancerous Moles |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Flaking or Itchy Scalp | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Basal Cell Skin Cancer | <input type="checkbox"/> Hay Fever/Allergies | <input type="checkbox"/> Squamous Cell Skin Cancer |
| <input type="checkbox"/> Blistering Sunburns | | |
| <input type="checkbox"/> Melanoma | | |

Other: _____

PATIENT HEALTH QUESTIONNAIRE (continued)

Do you wear sunscreen? Yes No

If yes what SPF: _____

Do you tan in a tanning salon? Yes No

FAMILY HISTORY

Do you have a family history of Melanoma? Yes No

If yes, which relative/s? _____

Do you have a family history of Psoriasis? Yes No

If yes, which relative/s? _____

Do you have a family history of Eczema? Yes No

If yes, which relative/s? _____

Do you have a family history of Alopecia? Yes No

If yes, which relative/s? _____

SURGICAL HISTORY

Have you ever had difficulty stopping bleeding? Yes No

Do you require antibiotics prior to a surgical procedure? Yes No

Have you had an artificial joint replacement? Yes No If yes, when and where? _____

Do you have an artificial heart valve? Yes No

Do you have a pacemaker? Yes No

Do you have a defibrillator? Yes No

PREGNANCY

Are you pregnant or currently trying to get pregnant? Yes No

MEDICATIONS

Are you currently on prescription medication? Yes No If yes, please list:

Do you take over-the-counter drugs, vitamins, supplements or use inhalers? Yes No

If yes, please list: _____

PREFERRED PHARMACY INFORMATION

Prescriptions will be sent electronically to your pharmacy

Pharmacy Name: _____ Phone: _____

Address: _____

ALLERGIES

Do you have any allergies? Yes No

If yes, what? _____

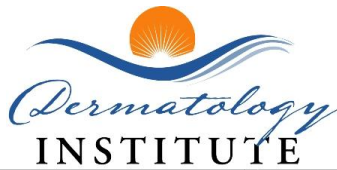
SOCIAL HISTORY

Please check all that apply.

currently smokes drug use

has smoked in the past alcohol use

Other: _____



OF SOUTHERN CALIFORNIA

IF ANY OF THE FOLLOWING QUESTIONS CONCERN YOU PLEASE CHECK THE APPROPRIATE BOX

- Do you have unwanted wrinkles? Yes No
- Do you have increased skin laxity? Yes No
- Are you interested in using topical Anti-Aging products? Yes No
- Do you have acne scars or Brown Spots? Yes No
- Do you suffer from excessive sweating? Yes No
- Do you have stubborn fat that diet and exercise don't seem to get rid of? Yes No

We at the Dermatology Institute of Southern California believe in the addition of a skin care regimen Backed by Science to compliment your medical care in our office.

If you would like to learn more about evidence based skin care products please check here